

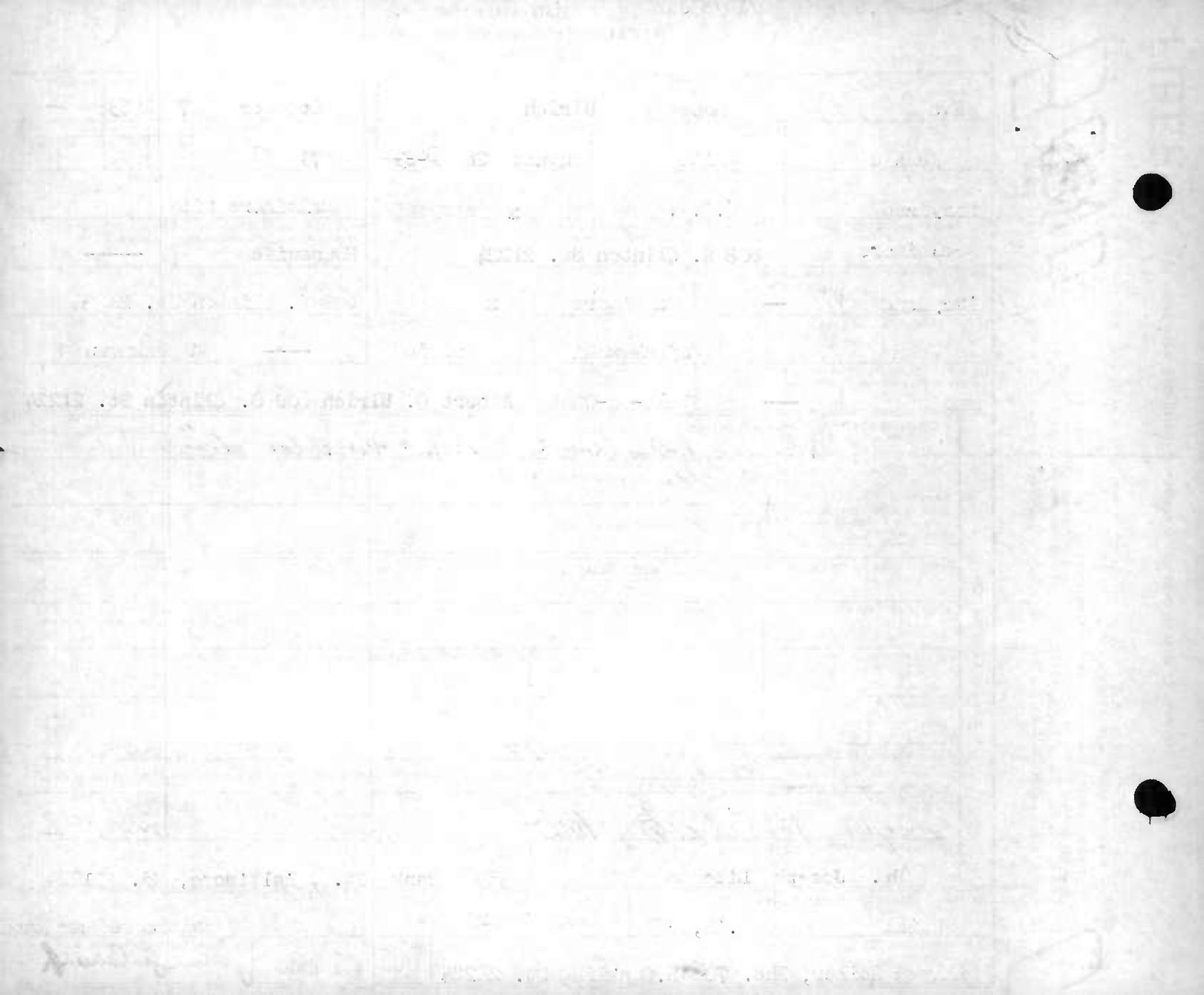
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner's inquest held.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Eva Rose Ulrich					2a. DATE OF DEATH MONTH DAY YEAR October 7 1983					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 26 1902		6. AGE (IN YEARS LAST BIRTHDAY) 71 81 YRS.		7b. HOUR — M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 608 S. Clinton St. 21224			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Zajackowski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fronie ? Unknown ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 219-01-0246		17. INFORMANT ADDRESS Albert G. Ulrich 608 S. Clinton St. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apertum Carotid-Vascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19</u> , 19 <u>82</u> , to <u>10/7</u> , 19 <u>83</u> , that (I) <u>last</u> saw the deceased alive on <u>10/6</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.										
22b. SIGNATURE Joseph B. Liberto, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/10/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Liberto					22e. ADDRESS 3508 Bank St., Baltimore, Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 11, 1983		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 700 S. Conkling St. 21224					25a. DATE REC'D. BY REGISTRAR OCT 11 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 7 1 2 4			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES W. UNDERWOOD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 10 83</b>			
3. SEX <b>Male</b>				4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 10 17</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Underwood</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Brittingham</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-01-8813</b>		17. INFORMANT ADDRESS <b>Marguerite Dennis 11 W. 20th Street</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). <b>Carcinoma</b>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Large Cell Ca Lung</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Antero-septal Myocardial Infarction / Pneumonia / Brain Metastasis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>Pending</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/23</b> , to <b>10/10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert A. Miller</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert A. Miller MD</b>		22e. ADDRESS <b>Union Memorial Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F.H. 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>OCT 13 1983 [Signature]</b>			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR			
RUTH M. UPHOFF						OCT 8, 1983						5 <sup>30</sup> P M			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female			Cau.			2 11 16			67						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Pa.			U.S.A.						Balto CITY MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE			MFL NURSING HOME B.CH						Homemaker						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6729 5th Ave. 21222			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
August Savage						Augusta Kressler									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
no						216-36-9997			Frederick G. Uphoff Sr. 6729 5th Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
4029 IMMEDIATE CAUSE (a) <u>Bariumespiratory Arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>Hypertensive Dechance Vascular Disease</u>												year			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)															
stroke 1974 and 1979.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 2 Oct 83, 19 79, to 13 Oct 83, 19 83, that (I) (we) last saw the deceased alive on 8 Oct 83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE								DEGREE		22c. DATE SIGNED					
Edmunds Beacham MD										10 Oct 83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS							
E. G. BEACHAM MD								BALTIMORE City Hospitals							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				10-12-83		Oak Lawn Cem.				Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc. 6415 Belair Rd.								OCT 10 1983		John J. Conner					

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Melvin Urquhart</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-15-83</b>			2b. HOUR <b>M</b>	
SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 26 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>(Home) 8 S. Pulaski St.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8 S. Pulaski St. 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alonzo Urquhart</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Urquhart</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-12-7441</b>		17. INFORMANT ADDRESS <b>Josie Urquhart 8 S. Pulaski St. (23)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis</b> (c) <b>Cor Pulmonale</b>							APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1/83</b> to <b>10/15/83</b> that (I) (we) last saw the deceased alive on <b>5/1/83</b> above (we) did not view the body after death.							
22b. SIGNATURE <b>Howard B. Chen, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/18/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD B. CHEN, M.D.</b>				22e. ADDRESS <b>BON SECOURS HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-21-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Charles A. Rice FSPA</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO: THE SECRETARY OF THE AIR FORCE  
FROM: THE SECRETARY OF THE AIR FORCE

SUBJECT: [Illegible]

[Illegible]

[Illegible]



[Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 2 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HANS C. URTEZ</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>31</b> YEAR <b>83</b>			2b. HOUR <b>8:50 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>5</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <b>Hans</b> MIDDLE <b>Urtes</b> LAST <b>Clara</b>				15. MOTHER'S MAIDEN NAME FIRST <b>M.</b> MIDDLE <b>Smedbron</b> LAST <b>St. Claire Lane</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>470-18-1122</b>		17. INFORMANT <b>Audra Urtes</b>		7936 <b>St. Claire Lane</b> <b>Balto., MD. 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2030</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>83</b> , to <b>Oct. 31</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. S. E. Valone</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/31/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. E. VALONE</b>				22e. ADDRESS <b>BCH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN <b>White Marsh</b> COUNTY <b>Maryland</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 4 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1922 28 2 01



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-1234.

BP \_\_\_\_\_

DDMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						7 3 2 7 1 2 8					
1. DECEASED NAME (TYPE OR PRINT) <b>Erene C. Uvonoglov</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>10 06 83</b>				2b. HOUR <b>5:45 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 3 - 09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2122 P 617 S. Haddon St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN Mc Donald</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Kiseckee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-07-1253</b>		17. INFORMANT ADDRESS <b>2122 P 13 Barbara Mc Donald - 710 S. 49th St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-Respiratory Arrest</b> <b>6827</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Compensated cellulitis of R foot</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 17</b> , 19 <b>83</b> , to <b>Oct 6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Oct 5</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Bruce W. Holtz</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/6/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRUCE W. HOLTZ</b>				22e. ADDRESS <b>Balt. City Hosp. Balt Md. 2122 P</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-8-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>ZANNINO FUN. HOME</b>				ADDRESS <b>263 S. CONKLING</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 2 9

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY LOUISE VAN ARNAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 13, 1983</b>		2b. HOUR MIN. <b>5:05 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1900</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>83</b>		IF UNDER 24 HRS. HOURS MIN. <b>5:05 A</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NH</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13e. STREET ADDRESS <b>320 Rossiter Ave. 21212</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marshall Otto Edson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice H. Warren</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220 38 6801</b>		17. INFORMANT ADDRESS <b>William D. VanArnam, Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE-CAUSE (a) <b>Cerebrovascular Disease; History of</b> <b>4350</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Transient Ischemic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>attack</b> <b>stroke (Cerev)</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diffuse Osteoarthritis; Mild Senile Dementia</b>						
19a. DATE OF OPERATION <b>8/31/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>8/31/83</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8/31/83</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/31/83</b> to <b>8/31/83</b> , that (I) (we) lost saw the deceased alive above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Lucila G. Canete R.O.</b>		DEGREE		22c. DATE SIGNED <b>10/12/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Lucila Canete, M.D.</b>		22e. ADDRESS <b>Wyman Park Hospital, Balto., MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>						
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto., MD 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Canineh</b>						

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WAVE JULY 14, 1945

1000 P.M. 1945

U.S.A. 1945

Union Memorial Hospital

2511 Rochester Ave., S.E.

Atlanta, Ga.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT VARGAS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 5 83</b>		2b. HOUR <b>2 22</b> A.M.
3 SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 28, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florida</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Psychologist - Self employed</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Victor Vargass</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caridad Gonzalez</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>267-48-5997</b>		17. INFORMANT <b>Key West, FL 33040</b> <b>Mrs. Zaida Fallon 404 Balido St.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5713

IMMEDIATE CAUSE (a) Disseminated intravascular coagulation

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) From neg. septicemia

DUE TO, OR AS A CONSEQUENCE OF

(c) Alcoholic liver diseaseAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> 19 <u>83</u> , to <u>10/5</u> 19 <u>83</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>10/5</u> 19 <u>83</u> , and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.			
22b. SIGNATURE <b>William D. Hicken</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>10/5/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.M. J. HICKEN, M.D.</b>		22e. ADDRESS <b>St Agnes Hosp. Balto, Md</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-7-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Key West Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Key West Monroe Florida</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc 8728 Liberty Rd. Randallstown, Md. 21133</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 3 1

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ANNA	MIDDLE K.	LAST VAUGHAN <del>VAUGHN</del>	2a. DATE OF DEATH MONTH DAY YEAR 10-24-83		2b. HOUR 1:22a.m.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 26 1943		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ESSKAY		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA STRUHR		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -				
16a. SOCIAL SECURITY NO. 219-40-1149		17. INFORMANT ANNA GLAESER			ADDRESS APT 718 21222 101 CENTER PLACE			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: SUBARACHNOID <del>SPONTANEOUS</del> HEMORRHAGE IMMEDIATE CAUSE (a) 4310 DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE CEREBROVASCULAR HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) seven days								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a HYPERTENSION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <del>XXXXX</del> 10-17 19 83, to 10-24- 19 83, that (1) (we) last saw the deceased alive on 10-24- 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.								
22b. SIGNATURE Mannisi MD		22c. DATE SIGNED 10/24/83					22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN MANNISI MD.	
22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 31		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						
23b. DATE 10/27/83		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.		23e. DATE REC'D. BY REGISTRAR OCT 26 1983		
23f. REGISTRAR'S SIGNATURE John J. Connelley		23g. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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VAUGHAN

DATE CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

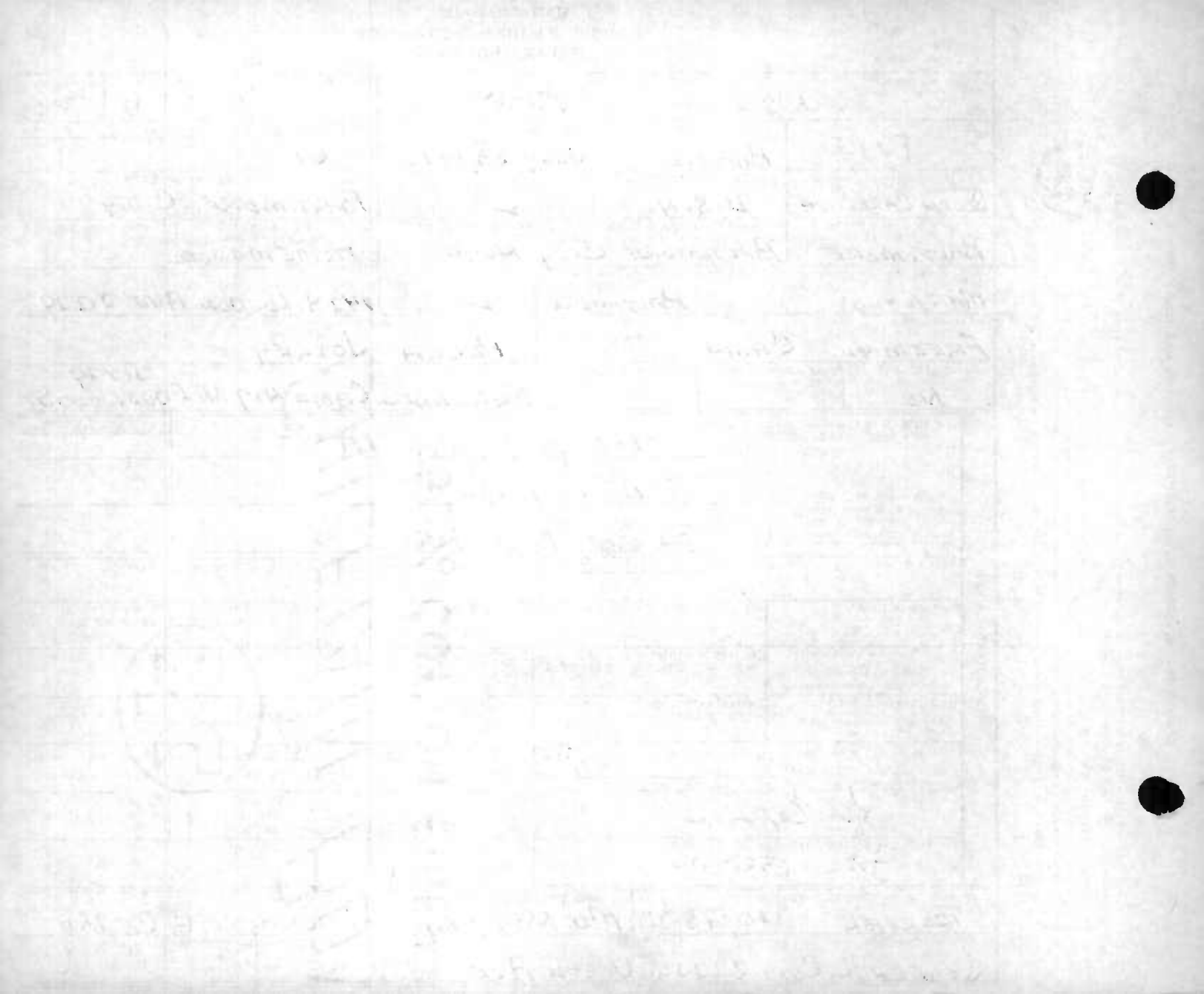
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 2 7 1 3 2			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLAUDIA VEALEY				2a. DATE OF DEATH MONTH DAY YEAR 10 25 82				2b. HOUR 1:20 P.M.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JULY 23, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 142 S. LOUDON AVE #1239			
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK CAMP				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PROLA JOLLEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS MELWEND CAMP 417 N. FOGGWOOD ST 31329							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHO PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>END-STAGE RENAL FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 9th</u> , 19 <u>82</u> , to <u>OCT. 25th</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>OCT. 25th</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE JOEL BERGZOW				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL BERGZOW				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (S) <u>BURIAL</u>				23b. DATE 10-28-83		23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. CA MD			
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS				ADDRESS 22324 NORTH AVE		25a. DATE REC'D. BY REGISTRAR NOV 2 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 83 27133	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. MATED <input type="checkbox"/> 10-28-83	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONRAD VICKERS										2b. HOUR M 10-28-83	
3. SEX male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7-17-1950		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEATH 10-28-83 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N.Y.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2113 Brookfield Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher City of Balto		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2113 Brookfield Ave 21217	
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD Vickers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Prince				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 104-40-4533	
17. INFORMANT Mrs. Grandoll Demegall				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stabwounds of chest 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10-?-83 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION 2113 Brookfield Avenue Baltimore, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10-28-83			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial				23b. DATE 11-3-83		23c. NAME OF CEMETERY OR CREMATORY Silver Mt Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Victory Blvd Staten Island N.Y.			
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 22224 North Ave.				25a. DATE REC'D. BY REGISTRAR OCT 31 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

INDEX

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New York N.Y.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 3 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DORIS VISHER			2a. DATE OF DEATH MONTH DAY YEAR 10 22 83			2b. HOUR 7:08 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 3 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Baltimore		16c. CITY OR TOWN Baltimore		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 1926 Hillenwood Road 21239	
17. FATHER'S NAME FIRST MIDDLE LAST Wilmer Cummings			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Thomas						
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-16-3715		20. INFORMANT ADDRESS Willie Visser 1926 Hillenwood Road					
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>5716</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hepatic-renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u>1° biliary cirrhosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>fractured R hip &amp; R humerus</u>									
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED				22c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
24a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE					
25. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> , 19 <u>83</u> , to <u>10-22</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10/22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
26a. SIGNATURE <u>David S. Dunn MD</u>				26b. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				26c. DATE SIGNED 10/22/83	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID S. DUNN				27b. ADDRESS 201 E. University PKwy					
28a. BURIAL, CREMATION, REMOVAL BURIAL		28b. DATE 10/28/83		28c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		28d. LOCATION BALTIMORE, COUNTY Md.			
29. FUNERAL DIRECTOR NAME Wm C March F/H Inc. 1101 E North Avenue				30. DATE REC'D. BY REGISTRAR OCT 25 1983		31. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>			

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2107



Item 13e phone 10-28-83en

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

8 3

2 7 1 3 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John W. Volz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-20-83</i>		2b. HOUR M <i></i>						
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-20-1933</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>50</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS <i></i>		IF UNDER 24 HRS HOURS MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS					
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3700 Green Spring Ave. 21211</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles A. Volz Sr.</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Hockett</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <i>Margaret K. Lotz - 7548 Belair Rd. - 21236</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 minutes</i> <i>10 years</i>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>June 17, 1983</i> to <i>August 19, 1983</i> , that (I) (we) last saw the deceased alive on <i>August 19, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/20/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frederic A. Morris M.D.</i>						22e. ADDRESS <i>5419 Falls Rd.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-23-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pennymar, Md.</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i>						25a. DATE REC'D. BY REGISTRAR <i>OCT 24 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27136

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lloyd O. Wade, Sr.		2a. DATE OF DEATH MONTH DAY YEAR Oct. 27, 1983		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1977		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1600 Popland St. Balto. Md. 21226		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic,	
12b. KIND OF BUSINESS OR INDUSTRY Machinery		13a. STATE Maryland		13b. COUNTY ---	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1600 Popland St. Balto. Md. 21226	
14. FATHER'S NAME FIRST MIDDLE LAST Clifton --- Wade		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa --- Simmons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 11-2 216-03-0249		17. INFORMANT Mrs. Mary J. Wade, Same as above	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 min

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY ARTERY INSUFFICIENCY

13 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

20 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Previous MYOCARDIAL INFARCTS (1970 &amp; 1975)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 13</u> , 19 <u>83</u> , to <u>Oct 27</u> , 19 <u>83</u> , that (I) <del>was</del> lost saw the deceased alive on <u>April 28</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.							
22b. SIGNATURE <i>Chh. J. Sullivan</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED OCT 28, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES O'Sullivan III, MD		22e. ADDRESS 9 EAST CHASE ST BALTIMORE, MD 21202					

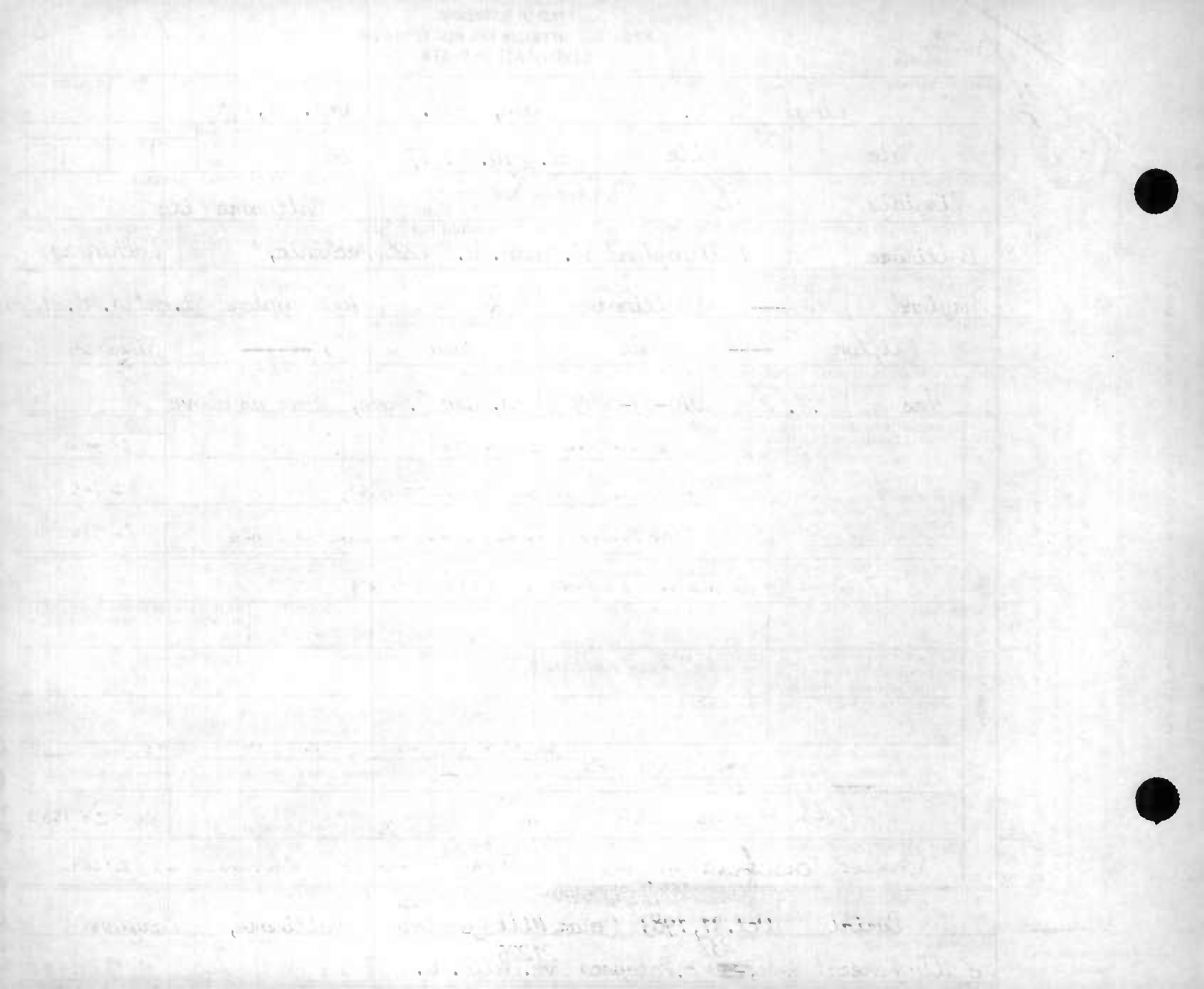
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 31, 1983	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME McClully Funeral Home		25a. DATE REC'D. BY REGISTRAR OCT 31 1983	
25b. REGISTRAR'S SIGNATURE John J. Carver		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>WINFORD CLINTON WAGNER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10-17-83</b>			2b. HOUR <b>9:30 pm</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOSPITAL, INC.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COMPUTER OPER.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFR.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>27 YORKWAY 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>KENNETH WAGNER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BLANCHE HAND</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>705-10-9169</b>		17. INFORMANT ADDRESS <b>ROSE C. WAGNER (same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COMA</b> <b>2000</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCITES, CIRRHOSIS, GASTROINTESTINAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>XX HISTIOCYTIC LYMPHOMA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>9-26-</b> 19 <b>83</b> , to <b>10-17-</b> 19 <b>83</b> , that (2) <del>the</del> <sup>now the deceased alive on</sup> <del>above</del> <sup>above</sup> , (3) <del>the</del> <sup>the</sup> <del>deceased</del> <sup>deceased</sup> did not view the body after death, and that in (my) <del>my</del> <sup>my</sup> opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>Vikas Sani</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10-17-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIKAS SANI</b>				22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 2524 GULFORD AVE 21218</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>10/20/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEM.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		
24. FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY, INC.</b>				ADDRESS <b>DUNDALK, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>10-24-1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

BP.

2010 10 10



Handwritten notes and signatures at the bottom of the page, including the date 2010 10 10 and various illegible markings.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 3 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mildred E. Walker</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>2</b> YEAR <b>83</b>		2b. HOUR <b>3:30</b> P.M.
3. SEX <b>Female</b>	4. RACE <b>Blk.</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>19</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Taylor's Is. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton med. center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>NONE</b>	13c. CITY OR TOWN <b>BALTO</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3301 Elgin Ave. 21216</b>
14. FATHER'S NAME FIRST <b>Goldsborough</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b>Otha</b> LAST <b>Otha</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-1419</b>		17. INFORMANT ADDRESS <b>Mrs. Bernice Heyward 3301 Elgin 21216</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

7070

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 13</b> , 19 <b>83</b> , to <b>Oct 2</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>Oct 18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J.W. Reed M.D.</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.W. REED</b>		22e. ADDRESS <b>611 S. CHAS. ST. BALTO. MD. 21230</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10-5-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Mem PK.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>RANDALLSTOWN, Md.</b>
24. FUNERAL DIRECTOR NAME <b>JAS. A. MORTON &amp; SONS</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1983</b>	
ADDRESS <b>1701 LAURENS</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>TYESHA Nichelle WALKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/26/83</b>		2b. HOUR P <b>6:20 M</b>
3. SEX <b>Female</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 21 82</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>1</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>WICOMICO</b>	13c. CITY OR TOWN <b>SALISBURY</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kenneth Walker</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Debra GASKINS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-02-2649</b>	17. INFORMANT ADDRESS <b>Debra Gaskins</b> <b>Same AS Above</b>		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

3229

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **BRAIN SWELLING**

DUE TO, OR AS A CONSEQUENCE OF

(c) **MENINGITIS**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

30 hours

36 hours

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/25/83</b> to <b>10/26/83</b> , that (I) (we) last saw the deceased alive on <b>10/26/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.			

22a. SIGNATURE <b>C. Schlessen</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>10/26/83</b>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. SCHLESSEN</b>	22d. ADDRESS <b>JOHNS HOPKINS HOSP. BALTO, MD</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10-31-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Mem. Park</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALISBURY WICOMICO Md.</b>
24. FUNERAL DIRECTOR NAME <b>Jolley Memorial Chapel</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Gass</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the funeral home. Page 3 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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A/W

WATER:

oh

513-05-5649 DEPTA GASKETS

SVODA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Harold Rudolph Wall					2a. DATE OF DEATH MONTH DAY YEAR Oct. 28, 1983			2b. HOUR M	
3 SEX male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/ 23/ 1911		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic-Balto.		12b. KIND OF BUSINESS OR INDUSTRY Annapolis	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Rossville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9223 Phila. Rd. Balto. 21237 Md.	
14 FATHER'S NAME FIRST MIDDLE LAST Rudolph Wall					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Gertz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-09-0040		17 INFORMANT Harold J. Wall 6001 Gordon Dr. Sunderland, Md. 20689					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i>								APPROXIMATE INTERVAL FROM ONSET AND DEATH <i>20 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>April 28, 1983</i> to <i>April 28, 1983</i> , that (I) (we) last saw the deceased alive on <i>April 28, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/29/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lassahn Funeral Home					22e. ADDRESS 7401 Belair Rd. (21236)				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 11/1/83		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24 FUNERAL DIRECTOR NAME Lassahn Funeral Home					25a. DATE REC'D. BY REGISTRAR NOV 10 1983				

NOV 10 1953

22

NOV 10 1953

NOV 10 1953

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NOV 10 1953

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NOV 10 1953

NOV 10 1953

NOV 10 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 4 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SHIH YI</b>		FIRST MIDDLE LAST <b>WANG Ph.d.</b>		7a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 3, 1983</b>		7b. HOUR <b>10:42<sub>AM</sub></b>	
3. SEX <b>Male</b>		4. RACE <b>Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 15, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor Johns Hopkins</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>14 Windemere Parkway 21205</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Yin Wang</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Li Kung</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>011-28-8552</b>		17. INFORMANT ADDRESS <b>Mrs. Chun Lien Wang Same as #13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1539 IMMEDIATE CAUSE (a) Respiratory Arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 1 min</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Colon Carcinoma</b>						DUE TO, OR AS A CONSEQUENCE OF (c) <b>Dysrhythmia</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Morphine Sulfate Infusions To Control Pain</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/3 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>600 N. WOLFE ST. - BALTO MD</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/3 1983</b> to <b>10/5 1983</b> , that (I) (we) lost saw the deceased alive on <b>10/3 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.						22c. DATE SIGNED <b>10/3/83</b>	
22b. SIGNATURE <b>Mark S. Komrad MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark S. Komrad</b>		22e. ADDRESS <b>Johns Hopkins Hosp Tower 110</b>		22f. CITY OR TOWN <b>BALTO</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct. 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

TO HOSPITAL OR CLINIC: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then give the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation/removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED  
FEB 21 1960  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

DATE

TIME

BY

TO

RE

FROM

SUBJECT

REMARKS

Mr. J. Edgar Hoover, Director, FBI

Washington, D.C.

Re: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH E. WARD			2a. DATE OF DEATH MONTH DAY YEAR 10/4/83		2b. HOUR 10:30 P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 25 32	6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. STREET ADDRESS 1401 S. Carey Street 21230			
14. FATHER'S NAME FIRST MIDDLE LAST John S. Ward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kenner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-4588	17. INFORMANT Charles E. Ward 623 Nautilus Ave. 21225				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Left thoracotomy, left lower lobe resection for carcinoma</u>						
19a. DATE OF OPERATION 10/3/83	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>83</u> , to <u>10/4</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10/4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Malcolm Wilkinson		DEGREE M.D.			22c. DATE SIGNED 10/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MALCOLM WILKINSON M.D.		22e. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/13/83	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR OCT 14 1983		
				25b. REGISTRAR'S SIGNATURE John J. Coniff		

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Hope & French Home In. 4 W. W. Home. 21222  
Bridal 20 12 83 Glen Haven Cemetery Glen Burnie A.A. Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary L. WARD</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>16</b> YEAR <b>1983</b>			2b. HOUR <b>835 A.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>16</b> YEAR <b>1935</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS <b>48</b> DAYS <b>00</b> HOURS <b>00</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2214 Roslyn Ave. 21216</b>	
14. FATHER'S NAME FIRST <b>Williard</b> MIDDLE <b>Jones</b> LAST <b>Jones</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b>Davis</b> LAST <b>Davis</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219 30 5381</b>		17 INFORMANT ADDRESS <b>Louise Alexander 2214 Roslyn Ave. 21216</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 5715 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Liver cirrhosis &amp; Ascites</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>months.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>9/9/83</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>10.2.1983</b> to <b>10.16.1983</b> , that (I) (we) last saw the deceased alive on <b>10.16.1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Chong choon Han</b> DEGREE						22c. DATE SIGNED <b>10.16.1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Chong choon HAN</b>						22e. ADDRESS <b>10998 Hickory Ridge Rd. Columbia, Md. 21044</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR <b>Nutter and Sons Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) JACOB WARENICZ					2a. DATE OF DEATH MONTH DAY YEAR OCT. 25, 1983			2b. HOUR 1:00P <sup>M</sup>		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6-6-1889		6. AGE (IN YEARS LAST BIRTHDAY) 94		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 818 S. DEAN STREET 21224				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY REFINERY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 10 1956		17. INFORMANT ADDRESS BALTO. ANNA KIRKLAND 818 S. DEAN ST. MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Gen A-S</u> (c) <u>years</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19 <u>10/15/83</u> , to <u>10/25/83</u> , 19 <u>10/25/83</u> , that (I) (we) lost saw the deceased alive on <u>10/25/83</u> , 19 <u>10/25/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Raymundo Magno</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/26/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RAYMUNDO MAGNO						22e. ADDRESS 7811 WISE AVENUE BALTO. MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 10/28/1983		23c. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ELK RIDGE HOWARD MARYLAND			
24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOMES 7110 BELAIR RD.						25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Grief</u>		

MEDICAL CERTIFICATION

CHINA AIRWAYS  
SINGAPORE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1- FOR STATE REGISTRAR					27145	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
BESSIE E. WASHINGTON			October 31 1983		4:22 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	NEGRO	Dec. 25-1917	65 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.	U.S.A.		BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	THE UNION MEMORIAL HOSPITAL		Housewife		At home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3212 Vickers Rd. 21216	
13a. CITY OR TOWN						
Balto.						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				
George Bennett		Ella Cullison				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		218-22-9285		Mr. William T. Washington 3212 Vickers Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COLLAPSED LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible mucous plugging</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 h.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC ALCOHOLISM, POSSIBLE HEPATIC ENCEPHALOPATHY, CHRONIC BRONCHITIS, Fe deficiency anemia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from <u>October 31</u> , 19 <u>83</u> , to <u>October 31</u> , 19 <u>83</u> , that (II) <u>we</u> most saw the deceased alive on <u>October 31</u> , 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE			22c. DATE SIGNED	
Wendy Kloesz					10/31/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
WENDY KLOESZ, M.D.		THE UNION MEMORIAL HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial	11-5-83	Arbutus Mem. Park	Arbutus Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Randolph J. Collick		2431 E. Oliver St.		NOV 3 1983 Jan. J. Baird		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 3 2 7 1 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN - WASSERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 30 83</b>			2b. HOUR <b>5 A</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 28 30</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD				
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL OF BALTO.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SKIN CARE</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2839 MARNAT RD. 21209</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM GOODMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BELLE GALLUP</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213/12/6451</b>		17. IN SCOTT BARRACQUER 9027 MEADOW HTS. RD. <b>DO NOT WRITE IN THESE SPACES</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>4920</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COPD - End stage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema &amp; bronchospastic component</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Seizures</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>83</b> , to <b>10/30</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Elena Barraquer</b> MD					DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/30/83</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELENA BARRAQUER</b>					22e. ADDRESS <b>SINAI HOSP. OF BALTIMORE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>OCT. 31, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH JACOB ANSHE VESHEAR</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 27147			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 10-25-83			
1. DECEASED NAME FIRST MIDDLE LAST MABLE C. WATERS				2b. HOUR 5:15 PM			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR OCT. 11 1912		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3411 BATEMAN AVENUE		13f. ZIP CODE 21216					
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE CORBIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH CLAYTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 155 07 3395		17. INFORMANT ADDRESS MRS. MARY E. GASKINS 3828 SEQUOIA AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2030 CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-25-1983 to 10-25-1983, that (I) (we) last saw the deceased alive on 10-25-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Krishan M. Mathur				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHAN M. MATHUR				22e. ADDRESS 2600 LIBERTY HEIGHTS AVE BALTIMORE Md. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/31/83		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD.	
24. FUNERAL DIRECTOR LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE	

LEWIS T. GUYER 4517 LEXINGTON AVENUE

BURIAL 10/31/83 VENTURE MEN. PARK

BALTIMORE (BALTO.) MD.

x

NO

155 07 3395

MRS. MARY E. DAKIN 3828 SENECA AVENUE

CLAYTON 2152

WUTH

CONRIN

CLARKSON

BALTIMORE

x

3411 BAYVIEW AVENUE

2156

SOCIAL SECURITY

WATKINS

CO of A

x

OCT. 11

1973

64

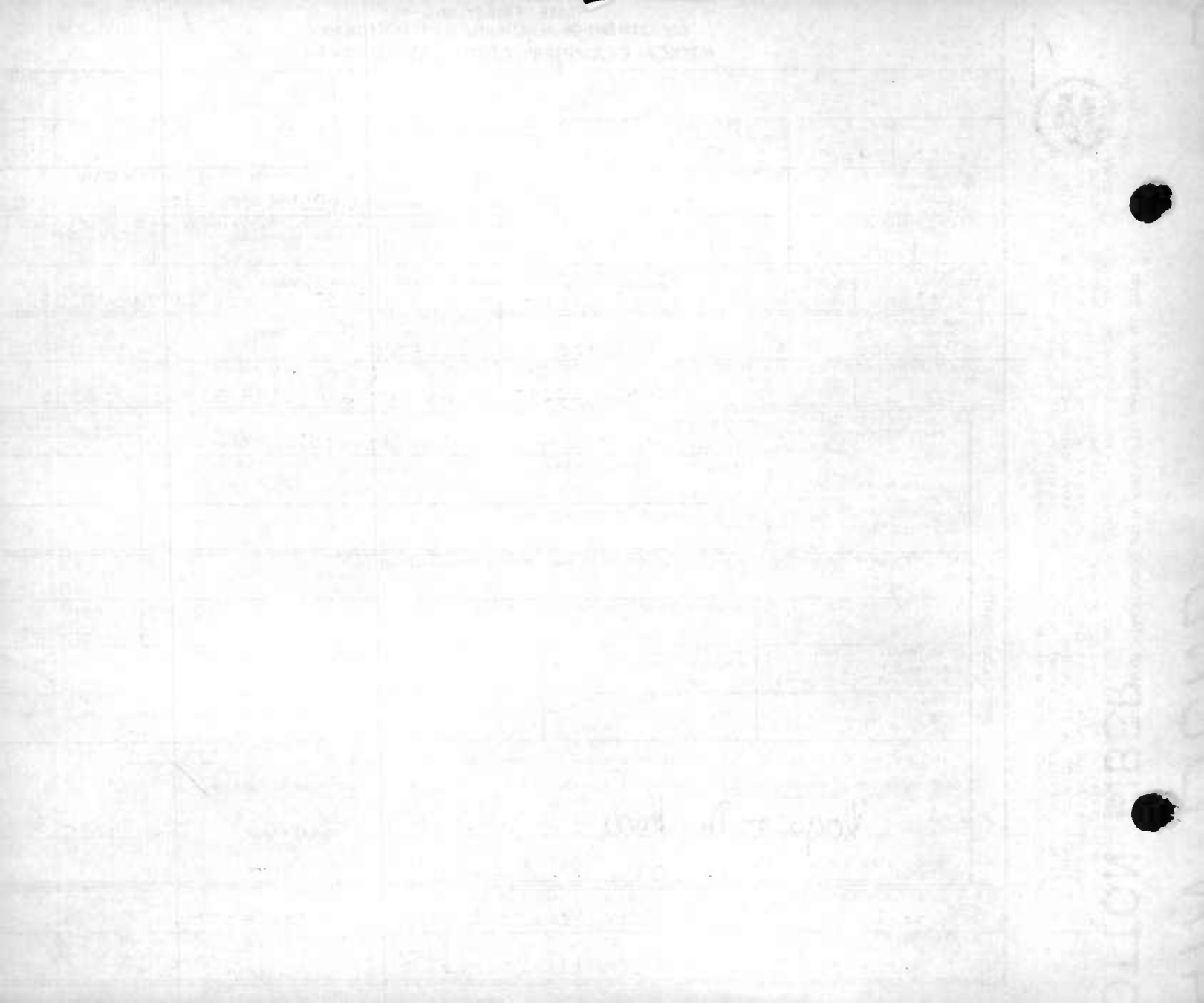
WATKINS

10/31/83

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CLARA A. WATKINS</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>10-27-83</b> DAY <b>19</b> YEAR <b>19</b>		2b. HOUR <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>31</b> YEAR <b>44</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>39</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>10-27-83</b> DAY <b>19</b> YEAR <b>19</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3155 Elmora Avenue 21213</b>		
14. FATHER'S NAME FIRST <b>Clarence</b> MIDDLE <b></b> LAST <b>Watkins</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Frances</b> MIDDLE <b></b> LAST <b>Greene</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-44-4411</b>			17. INFORMANT (Curley) ADDRESS <b>Anna Curbeam 3155 Elmora Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>obesity</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>10-28-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/1/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>			23d. LOCATION CITY OR TOWN <b>Randallstown,</b> COUNTY <b></b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 1 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

2 7 1 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Edward WATKINS			2a. DATE OF DEATH MONTH DAY YEAR 10-27-83		2b. HOUR 38 2 AM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 6 1921	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Charlotte co., VA.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Steel Worker	12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Russel Watkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Susan Rogers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. World War II 216-12-5649		
17. INFORMANT Bettie I. Watkins			ADDRESS Baltimore, Maryland 21216		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 5699 DUE TO, OR AS A CONSEQUENCE OF (b) possible pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Status post Exploratory Laparotomy					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 10/27/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ileostomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10/16 83 to 10/27 83	
22a. I certify that (I) (this hospital) attended the deceased from 10/16/83 to 10/27/83, that (I) (we) last saw the deceased alive on 10/27/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE John J. Arrisvendo		DEGREE		22c. DATE SIGNED 10/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARRISVENDO J.		22e. ADDRESS 730 Ashburton St. Baltimore MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/01/1983	23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Maryland
24. FUNERAL DIRECTOR NAME Nutter & Sons			25a. DATE REC'D. BY REGISTRAR OCT 31 1983		
25b. REGISTRAR'S SIGNATURE Funeral Home Inc. 2501 Gwynns Falls Pkwy.			25c. REGISTRAR'S SIGNATURE John J. Arrisvendo		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIB

CHIEFMAN



MADE IN U.S.A. 100% COTTON FIBRE  
WASH & TUMBLE DRY  
Groomville, California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

G#584 10/11/83 mtb Items 15 &amp; 17

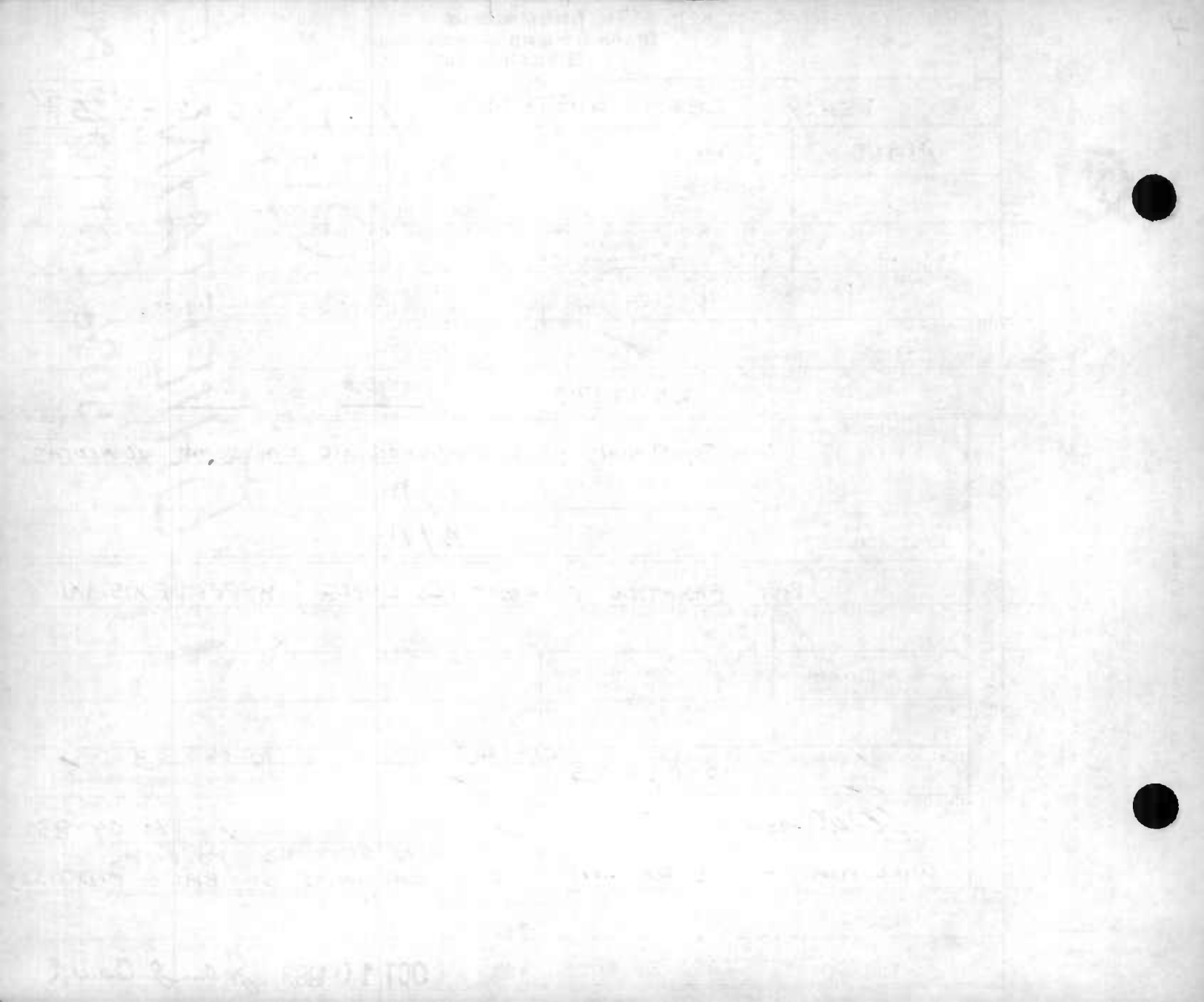
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>PERCY LEE WATKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 08 83</b>			2b. HOUR <b>5<sup>57</sup> P<sup>M</sup></b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 22 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1114 Lyndhurst St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Solomon Watkins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary -</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-12-1710</b>		17. INFORMANT ADDRESS <b>Watkins Eberly</b> <b>Patrick Watson 6516 Eberly Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL BRONCHOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>N/A</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>N/A</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MONTHS</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>POST RADIATION FIBROSIS (2) LUNG; HYPERTENSION</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>01-14 19 83</b> to <b>10-08 19 83</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10-03 19 83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>William R. Law MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-09-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM R. LAW MD</b>				22e. ADDRESS <b>BON SECOURS HOSPITAL</b> <b>2000 W. BALTIMORE ST BALTO. MD 21223</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown MD</b>	
24. FUNERAL DIRECTOR Nm. <b>C. March F/H</b> 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR <b>OCT 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 27 151

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR			
Lillian A. Watson			10-30-83			355 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
FEMALE	B	MONTH	DAY	YEAR	79	YRS.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Keyville, VA		U.S.				Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
BALTO. Md.			J.L. Deaton Med Ctr.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS		
Md.			BALTIMORE			21205 1525 Lester Horton Ct.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
RICHARD			Williams Jane West					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			217-03-5583			Volia Nicholas 1525 Lester Horton Ct		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.N.F. 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Heart Dis; Hypertensive & A.S. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 days years
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he/she) attended the deceased from saw the deceased alive on 6/12/83, 19 83, and that (my/our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.		22b. SIGNATURE J.A. Gladue, M.D.		22c. DATE SIGNED 10/31/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		11/3/83		Md. Nat. Mem. Pk.		Laurel, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H 1101 E. North Ave.				NOV 2 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON FIBRE

CHIEFLY



Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Wool", "Cotton", and "Fibre" are faintly visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Wool", "Cotton", and "Fibre" are faintly visible.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. REPORT TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <b>BRIAN JAMES WDZIENCZKOWSKI</b>								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>10-1-83</b>		2b. HOUR <b>19</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 24, 1960</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>22 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-1-83</b>	7d. HOUR <b>19</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-1-83</b>		2d. HOUR <b>19</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>- -</b>	13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>308 S. Madiera St. (21231)</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Casimier - Wdzienczkowski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Diane - Borowski</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- -</b>		17. INFORMANT ADDRESS <b>Diane Borowski 509 S. Chapel St. (21231)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio-cerebral injury</b> <b>8122</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:14AM 10-1-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of motorcycle/auto collision</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>E. Balto. Street &amp; Ann St. Balto., Maryland</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) <b>Assistant</b>				MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn Street</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 5, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>- - Baltimore Co., Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave./21231</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 5 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>				

MEDICAL CERTIFICATION

State of Maryland, Dec. 1, 1900

X

Notary Public

Inspector

Maryland, Baltimore, X

County of Baltimore, -

State of Maryland, X

Baltimore, - - - Baltimore Co., Md.

John A. Baker, Inc. 1001 North Ave. Baltimore

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Raymond G Webb</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 31 83</i>			2b. HOUR <i>1234</i> <sup>A</sup>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 8 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maint.</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Gen, Motors</i>		13a. STATE <i>Maryland</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>601 S. 46<sup>th</sup> Street 21224</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ythomas Webb</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Veronica Thorn</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>216 12 3132</i>		17. INFORMANT ADDRESS <i>Mrs. Raymond G. Webb 601 S. 46<sup>th</sup> Street 21224</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardio respiratory arrest.**4151*

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *presumed Pulmonary Embolism*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mur Hawke</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/31/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HAWKE</i>				22e. ADDRESS <i>POCH</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/3/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY MD <i>Baltimore</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Walter Dabrowski 1005 Dundalk Avenue</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 3 1983</i>	
						25b. REGISTRAR'S SIGNATURE <i>John J. Calver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



male	white	23	00
unemployed	USA		Baltimore City
Baltimore	Baltimore City Hospital		Gen. Motors
unemployed	Baltimore		col. S. W. Street 2124
Thomas	ebb	Veronica	Thorn
yes	110 E. 31st	rs. Raymond C. Webb Col S. W. Street 21	

11/3/33	Car Loan Company	Baltimore	386
after hours 11000 Duncas Avenue			

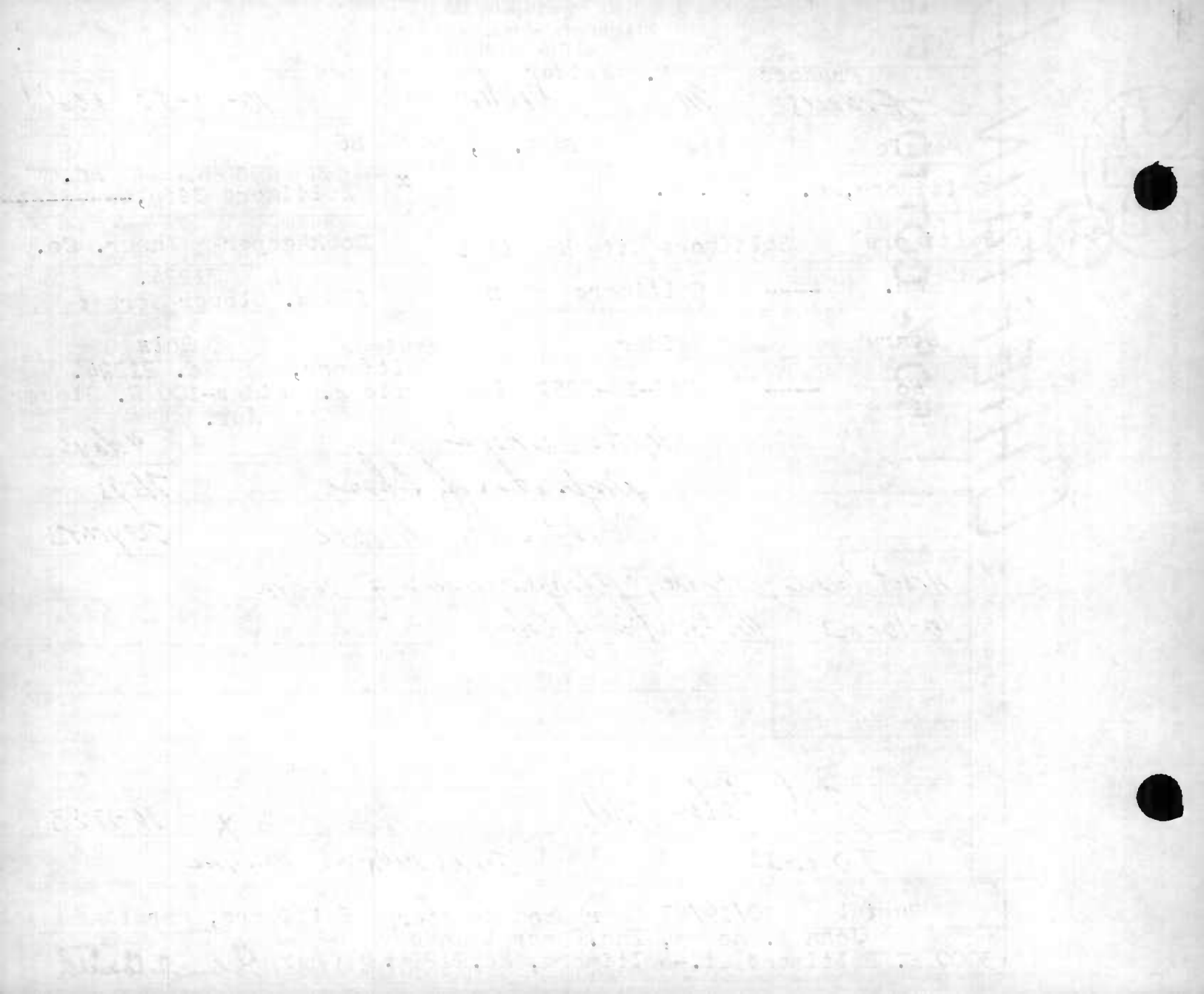
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 3 27 1 5 4	
CERTIFICATE OF DEATH				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>Frances M. Weider</b>		2a DATE OF DEATH MONTH DAY YEAR <b>10-17-83</b>		2b HOUR <b>4:36 PM</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Sept. 8, 1897</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) <b>Baltimore, Md.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, Hospital Md.</b>		
10 CITY OR TOWN OF DEATH <b>Baltimore</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Insur. Co.</b>	
13a STATE <b>Md.</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Henry Weider</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Genevieve Bolz</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-10-3257</b>		17 INFORMANT ADDRESS <b>Baltimore, Md. 21224.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock</b> <b>5621</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <b>Perforation of colon</b> (c) <b>Diverticular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>7 days</b> <b>20 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Heart disease, stroke, AdenoCarcinoma of vagina</b>					
19a DATE OF OPERATION <b>10-10-83</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforation of Colon</b>		19c AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21c LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death.					
22b SIGNATURE <b>J.D. Labs</b>		DEGREE		22c DATE SIGNED <b>10-17-83</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.D. LABS</b>		22e ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>10/19/83</b>	23c NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24 FUNERAL DIRECTOR NAME <b>John A. Moran, Inc. Funeral Home</b>		24b ADDRESS <b>3000 E. Baltimore St.-Baltimore, Md. 21224</b>		24c DATE REC'D. BY REGISTRAR <b>20 1983</b>	
		25 REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27155	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Robert L. Wellons (Wellann)</b>						2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 8 19 83</b>		2b. HOUR <b>8:20 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 17 34</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>49 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>10 8 19 83</b>		7d. HOUR <b>8:20 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21206 4833 Aberdeen Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert J. Wellons</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Corine Butler</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>218-28-1000</b>		17. INFORMANT ADDRESS <b>Rosa Lee Wellons 4833 Aberdeen Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4029 IMMEDIATE CAUSE (a) Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) <b>M. Deputy Chief</b>				DATE SIGNED <b>10/8/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>10/14/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>						ADDRESS <b>1101 E North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

NOTION FIBER

WYNN



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27156	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Lawrence C. Whalen</b>								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>10 7 1983</b>		2b. HOUR <b>AM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>9</b> YEAR <b>32</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>51</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH <b>10</b> DAY <b>7</b> YEAR <b>1983</b>		2d. HOUR <b>7:34P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sponger-Clothing Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Baltimore, Md. 529 Hazlett Ave. #21229</b>	
14. FATHER'S NAME FIRST <b>Lawrence</b> MIDDLE <b>Whalen</b> LAST <b>Margaret</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>Clewell</b> LAST <b>Clewell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-26-6142</b>				17. INFORMANT <b>Nancy L. Whalen</b> ADDRESS <b>529 Hazlett Ave., Balto., Md. 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>10/8/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Oct. 11, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City, Md.</b>			
24. FUNERAL DIRECTOR <b>G. Truman Schwab</b>				ADDRESS <b>5151 Balto. Nat'l. Pike #21229</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1983</b>			

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]  
[Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOIS D. WHEATCRAFT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-22-83</b>		2b. HOUR 7:31 P.M.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 25, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS / ZIP CODE <b>3433 Green Mount Ave. 21218</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Loris Alexander Magnani</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth M. Doster</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-38-5108</b>		17. INFORMANT ADDRESS <b>Arthur Wheatcraft 3433 Green Mount Ave. 21218</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Breast Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>712 no</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>83</b> , to <b>10-22</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Simon V. Scain</b>			DEGREE			22c. DATE SIGNED <b>10-22-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Simon V. Scain</b>			22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Oct. 24, '83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd.</b>			25a. DATE REC'D. BY REGISTRAR: <b>OCT 24 1983</b> 25b. REGISTRAR'S SIGNATURE: <b>John J. Lohr</b>			

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR ITEM 4 10-4-83 cnphone					7 3 2 7 1 5 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GERALD WILSON WHEELER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10 23 83</b>	
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 23 17</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>65</b> YRS.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL HOSP.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEELWORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO.</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY WILSON WHEELER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA SHIVE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>W.W.2 198-07-4160</b>		17. INFORMANT ADDRESS <b>LILLIAN WHEELER BALTO. MD. 21222</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ESOPHAGEAL CANCER</b> <b>1509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION <b>7/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RETOPHAGEAL STRICTURE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>83</b> to <b>October</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John Frederick</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/23/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDERICK</b>		22e. ADDRESS <b>50614</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL CEM</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>WHITEHAVEN PENNA.</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 28 1983</b>				
24. FUNERAL DIRECTOR NAME <b>McHUGH T.H.</b>		ADDRESS <b>403 BERWICK ST. PENNA.</b>		25b. REGISTRAR'S SIGNATURE <b>See 2 Card</b>		

RECEIVED  
JAN 12 1963  
FBI - NEW YORK

TO: DIRECTOR, FBI (100-388610)  
FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA  
RE: NEW YORK TELETYPE TO BUREAU, JANUARY 11, 1963

RE: BUREAU TELETYPE TO NEW YORK, JANUARY 10, 1963  
RE: BUREAU TELETYPE TO NEW YORK, JANUARY 9, 1963

RE: BUREAU TELETYPE TO NEW YORK, JANUARY 8, 1963  
RE: BUREAU TELETYPE TO NEW YORK, JANUARY 7, 1963

RE: BUREAU TELETYPE TO NEW YORK, JANUARY 6, 1963  
RE: BUREAU TELETYPE TO NEW YORK, JANUARY 5, 1963

RE: BUREAU TELETYPE TO NEW YORK, JANUARY 4, 1963  
RE: BUREAU TELETYPE TO NEW YORK, JANUARY 3, 1963

RE: BUREAU TELETYPE TO NEW YORK, JANUARY 2, 1963  
RE: BUREAU TELETYPE TO NEW YORK, JANUARY 1, 1963

RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 31, 1962  
RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 30, 1962

RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 29, 1962  
RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 28, 1962

RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 27, 1962  
RE: BUREAU TELETYPE TO NEW YORK, DECEMBER 26, 1962



CHIEF OF POLICE

NEW YORK

RELEASED AS NON-MED PER MR. GREGORY &amp; DR. SMITH - MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon against page 1, and if available, the following after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be signed by a physician who notified the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HELEN M. WHITE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 25, 1983</b>			2b. HOUR A <b>2:23<sub>M</sub></b>			
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 6, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Reids Grove, Md.</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
12. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Rhodesdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>Rt. 1, Box 204</b>			13f. ZIP CODE <b>21659</b>						
17. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Rideout</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nona Dennis</b>						
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			19b. SOCIAL SECURITY NO. <b>219-07-3830</b>		19c. INFORMANT ADDRESS <b>Albert White, Rt. 1, Box 204, Rhodesdale, Md. 21659</b>				
20. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7991 IMMEDIATE CAUSE (a) Respiratory arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
24a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			24c. LOCATION STREET CITY OR TOWN COUNTY STATE			
25a. I certify that (I) (this hospital) attended the deceased from <b>10/25/83</b> to <b>10/25</b> 19 <b>83</b> , that (I) (we) saw the deceased alive on <b>10/25</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
26a. SIGNATURE <b>S. N. Kahane</b>			26b. DEGREE <b>M.D.</b>			26c. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		26d. DATE SIGNED <b>10/25/83</b>	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. N. Kahane</b>			27b. ADDRESS <b>Johns Hopkins Hospital</b>						
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			28b. DATE <b>Oct. 29, 1983</b>		28c. NAME OF CEMETERY OR CREMATORY <b>Reids Grove Cemetery</b>		28d. LOCATION CITY OR TOWN COUNTY STATE <b>Reids Grove, Dorchester, Md.</b>		
29a. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home, 216 N. Main St.</b>			29b. ADDRESS <b>Federalsburg</b>			29c. DATE REC'D. BY REGISTRAR <b>OCT 31 1983</b>		29d. REGISTRAR'S SIGNATURE <b>John J. Gough</b>	

BP \_\_\_\_\_

BOARD

MEMBER

Representative

10/22/62  
10/22/62  
10/22/62

10/22/62  
10/22/62  
10/22/62

10/22/62  
10/22/62  
10/22/62

VOID

CERTIFICATE # 27160



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 6 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William N. White</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 23, 1983</b>		2b. HOUR <b>9:35A M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 5 31</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>823 N. Gilmore Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William N. White</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Latrice Cook</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		16b. SOCIAL SECURITY NO. <b>216-12-3920</b>		17. INFORMANT ADDRESS <b>Elvenia Madison 823 N. Gilmore Street</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

**Diabetes Mellitus, Pulmonary Emboli, Seizure Disorder**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 2, 1983</b> to <b>October 23, 1983</b> , that <input checked="" type="checkbox"/> (we) lost <b>October 23, 1983</b> , and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <b>not</b> view the body after death.			
22b. SIGNATURE <b>Janice Rutkowski, M.D.</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>10/23/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Janice Rutkowski, M.D.</b>		22e. ADDRESS <b>c/o Maryland General Hospital</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>10/29/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY <b>Lansdowne, Md.</b>
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>	25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1983</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Grier</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9-12A

October 22, 1983

White

William

Baltimore City

Harland General Hospital

Baltimore

Bronchopneumonia

Diabetes Mellitus, Pulmonary Emboli, Scurvy Disorder

X

83

October 22,

83

October 22, 83  
XX

October 22,

XXX

10/23/83

Harland General Hospital

Jonice Gutowski, M.D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 / 2 7 1 6 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM PRESTON WHORTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 17 83</b>			2b. HOUR <b>0915</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seafood Merchant</b>		12b. KIND OF BUSINESS INDUSTRY <b>Whorton U. Preston Inc.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>514 S. Rolling Road 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Whorton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bettie Woodard</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-01-1808</b>		17. INFORMANT ADDRESS <b>Della Whorton Same as # 13</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:4920 IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **SEVERE EMPHYSEMA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a

**ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

19a. DATE OF OPERATION <b>NONE RECENT</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>83</b> , to <b>10/17</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Peter G. Wallick</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER G. WALLICK, M.D.</b>				22e. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 18 1983</b>		REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



William Weston WESTON

White T. B. E. 1917

North Carolina U.S.A.

Barbours Park, Barbours, Ind.

Barbours Park, Barbours, Ind. 21228

Barbours Park, Barbours, Ind. 21228

21228-1928 U.S. Weston James 19

Burial 10/20/22 Wilma Valley Cemetery

John C. Wilma Valley Cemetery, 21228, 10/20/22

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 6 3

FOR  
1- STATE  
REGISTRAR

REG. NO.

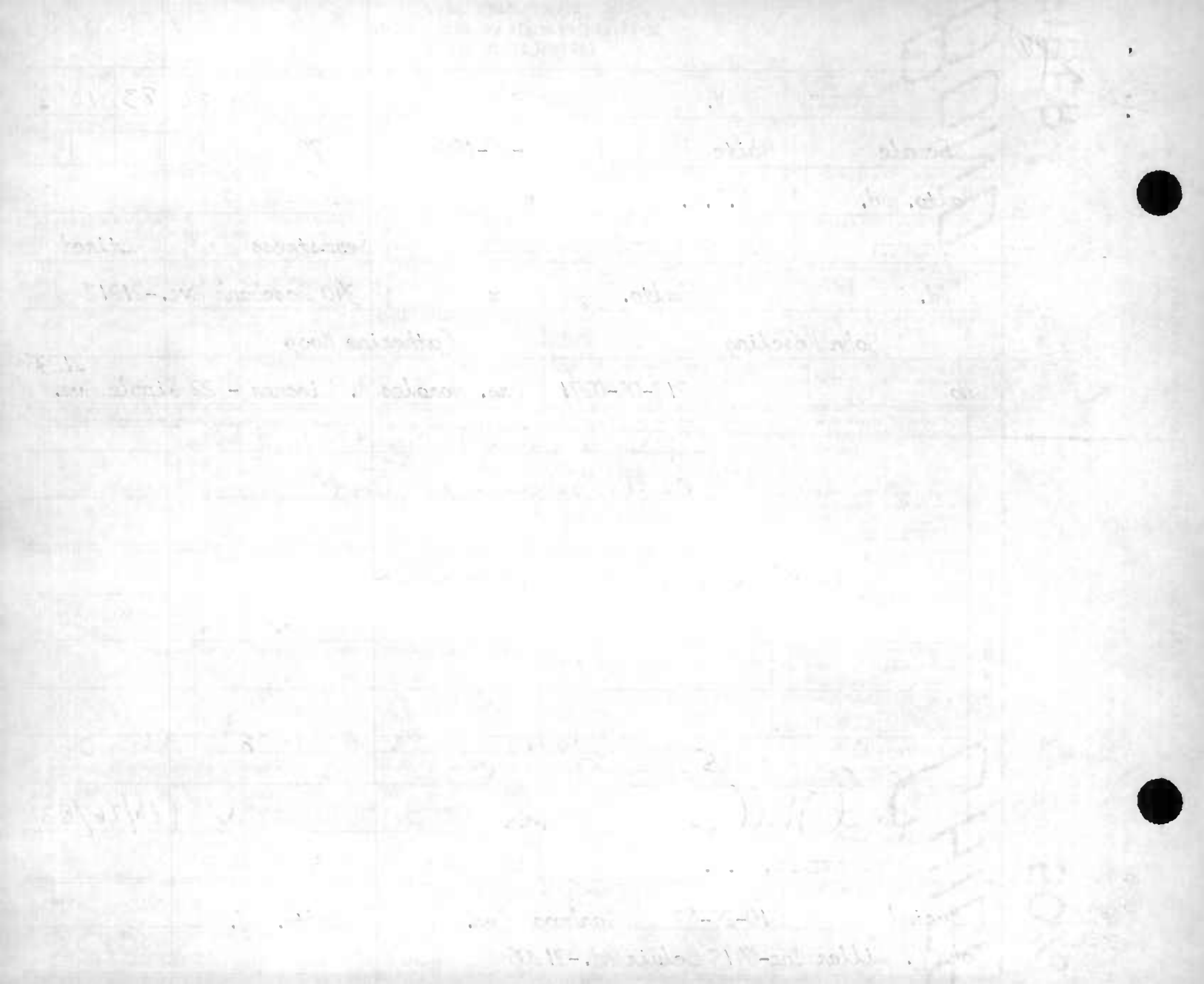
1. DECEASED NAME (TYPE OR PRINT) <b>EVELYN V. WIESNER</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>26</b> YEAR <b>83</b>			2b. HOUR <b>10<sup>4</sup> AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>20</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>340 Rosebank Ave. - 21212</b>		
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Keseling</b> LAST <b></b>				15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b>Koop</b> LAST <b></b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-05-0271</b>	
17. INFORMANT <b>Mrs. Dolores M. Wiesner - 22 Sipple Ave.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypoxia secondary to congestive heart failure</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21236</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Possible aspiration pneumonia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>10/24</b> , 19 <b>83</b> , to <b>10/26</b> , 19 <b>83</b> , that (b) (we) last saw the deceased alive on <b>10/25</b> , 19 <b>83</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul Miller</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/26/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL MILLER, M.D.</b>			22e. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-29-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE				
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.</b> ADDRESS <b>-21206</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Mary E. Wiley</b>					2a. DATE OF DEATH MONTH <b>10</b> DAY <b>26</b> YEAR <b>83</b> 2b. HOUR <b>1:30</b> P.M.				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>8</b> YEAR <b>23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1701 Eutaw Place</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1701 Eutaw Pl. 21217</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b></b> LAST <b>White</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Henrietta</b> MIDDLE <b></b> LAST <b>White</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-16-9982</b>		17. INFORMANT ADDRESS <b>James Wiley 1701 Eutaw Pl. 21217</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Breast with</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastases to cervical spine and brain.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10</b> 19 <b>83</b> to <b>Oct 26</b> 19 <b>83</b> , that (I) (we) lost above, the deceased alive on <b>Oct 26</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>George Taler, M.D.</b>					DEGREE <b></b>		22c. DATE SIGNED <b>Oct 28, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Taler, M.D.</b>					22e. ADDRESS <b>600 Light St. Balt. Md. 21230</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-31-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville A.A. Md</b>			
24. FUNERAL DIRECTOR NAME <b>Charles A. Rice FSPA</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>		

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 6 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MELONIE</b>			FIRST MIDDLE LAST <b>WILHELM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 9, 1983</b>			2b. HOUR <b>10:04A</b>					
3 SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>6 25 57</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>26</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL 21205</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>3036 Keswick Rpad 21211</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vernon Lee Fair</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Shirley E. Bopst</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-78-6732</b>			17. INFORMANT ADDRESS <b>Mr. Vernon Fair 3037 Keswick Road 21211</b>								

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**2799**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Overwhelming Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Immunoconpromise 2° Systemic LE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**Herpes pneumoniae Nocardia pneumoniae Acute renal failure Hyperkalemia Respiratory Failure**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 8, 1983</b> to <b>October 9, 1983</b> , that (I) (we) last saw the deceased alive on <b>October 9, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kevin J. Twohig</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kevin J. Twohig</b>				22e. ADDRESS <b>600 N. Wolfe St Balto, Md. 21205</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
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24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>		ADDRESS <b>3818 Roland Avenue 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are to be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 3 and 4 are to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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growth

A. Alan Lewis, Jr. 3818 Roland Avenue 11511

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27166

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD F WILLEM JR			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 4, 1983		2b. HOUR 4:30AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 18 <sup>th</sup> 1938	6. AGE (IN YEARS LAST BIRTHDAY) 45	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Willem, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wroten		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-26-9654		17. INFORMANT Donna Willem	ADDRESS SAME 13c	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>VENTRICULAR ECTOPY</u> (c) <u>Ventricular Ectopy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>August 19, 83</u> to <u>OCT 4</u> , 19 <u>83</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>OCT 4</u> , 19 <u>83</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.			
22b. SIGNATURE <u>George E Larocco M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>10/4/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE E LAROCCO M.D.		22e. ADDRESS 7620 YORK RD BALTO., MD 21204	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-7-1983	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc 5305 Harford Rd.		25a. DATE REC'D. BY REGISTRAR OCT 5 - 1983	25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, papers should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

EDWARD F. WILLIAM J. VICTOR A. 1980 A-32A

also July 10 1980

NAT. INS. U.S.A. BALTIMORE COUNTY

ST. JOSEPH HOSPITAL

3017 - 3018 Ave

Alison, Dr.

119-120-121

ACUTE MYOCARDIAL INFARCTION

CARDIAC ARREST

VENTRICULAR FIBRILLATION

20% COL



GEORGE F. LARSON

10-1-1981

Insurance Co. Inc. 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY S. WILLETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 12 83</b>			2b. HOUR <b>6:45 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 25, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3522 Buena Vista Avenue 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Theodore Willett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Jane Bucher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 20 8818</b>		17. INFORMANT ADDRESS <b>Dorothy S. Willett Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION <b>9 9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/20</b> , 19 <b>83</b> , to <b>10/12</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/12</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Brian H. Kahn, M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN H. KAHN M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Balto. Co. Md</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Burgee Funeral Home 3631 Falls Road 21211</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Gifford</i>			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



202<sup>ND</sup> COLLOID  
CHIEFLY



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Antonio J. Williams				2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10 28 1983				2b. HOUR M 5:40 P. M.	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 26 82	6. AGE (IN YEARS) LAST BIRTHDAY 1 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 28 1983	2d. HOUR M 5:40 P. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3123-75th Avenue #2 20785			
13a. STATE MD	13b. COUNTY Prince Georges	13c. CITY OR TOWN Landover							
14. FATHER'S NAME FIRST MIDDLE LAST Antonio J. Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stephanie Marshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Stephanie Marshall 3123-75th Avenue #2 Landover, MD 20785					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt trauma to head with complications</u> 9682 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 P.M. 2/8 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was assaulted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6610 District hghts Pkwy. Apt. 4 P.G. Co. Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i> M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 10-29-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/83		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince Georges MD		
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20012									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



WASHINGTON D.C. 20019  
4339 HUNT PLACE, N.E.  
ROLLINS FUNERAL HOME, INC.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ARNOLD J. WILLIAMS, JR.</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>23</b> YEAR <b>83</b>			2b. HOUR <b>840p.m.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>22</b> YEAR <b>'41</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY OF MD HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE SHOP</b>	
13a. STATE <b>PA.</b>			13b. COUNTY <b>WYOMING</b>		13c. CITY OR TOWN <b>NOXEN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>ARNOLD</b> MIDDLE <b>J.</b> LAST <b>WILLIAMS, SR.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>MARGARET</b> MIDDLE <b>MAIDEN</b> LAST <b>EVANS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>193-32-1001</b>		17. INFORMANT (WIFE) <b>PRISCILLA M. WILLIAMS</b>			ADDRESS <b>SAME AS #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>2040</b> IMMEDIATE CAUSE (a) <b>probable cerebral herniation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Central Nervous System Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Non Symphocytic Leukemia</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> , 19 <b>83</b> , to <b>10/23</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/23</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Scott Thomas Maurer MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT THOMAS MAURER MD</b>			22e. ADDRESS <b></b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/27/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FERN KNOLL BURIAL PARK</b>		23d. LOCATION CITY OR TOWN <b>DALLAS</b> COUNTY <b>LUZERNE</b> STATE <b>PA.</b>		
24. FUNERAL DIRECTOR NAME <b>E. BARNES</b> ADDRESS <b>81018</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 25 1983</b>			25b. REGISTRAR'S SIGNATURE <b>Ann J. Carney</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



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BALTIMORE CITY

BALTIMORE UNIVERSITY OF PROTESTANT LITERATURE  
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BALTIMORE, MD. 21201

ARCHD. 1. 1200. X  
BALTIMORE, MD. 21201  
BALTIMORE, MD. 21201

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10/11/83  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

BP \_\_\_\_\_  
DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 7 1 7 0 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) <b>ATHALIA MAE WILLIAMS</b>				MONTH <b>10</b> DAY <b>13</b> YEAR <b>83</b>		2b. HOUR <b>4:40 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>4</b> DAY <b>23</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1214 EUTAW Place</b>		13f. ZIP CODE <b>21217</b>					
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE LAST <b>Vinyard</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sally</b> MIDDLE LAST <b>Hewes</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO <b>214-14-5655</b>		17. INFORMANT <b>755 216th St. Pasadena,</b>		ADDRESS <b>MD. 21122</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac pulm many arrest</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration Pneumonia, Infected</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decubitus ulcer, R/L legs</b> <b>D.M., ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Suwanagool</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. SUWANAGOO</b>		22e. ADDRESS <b>Lutheran Hospital MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/7/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> NAME ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. C...</b>	

ATHLETIC MAE WILLIAMS

WHITE 4 23 10

FEMALE

13

FAIRMORE CITY

✓  
LUTHERAN HOSPITAL

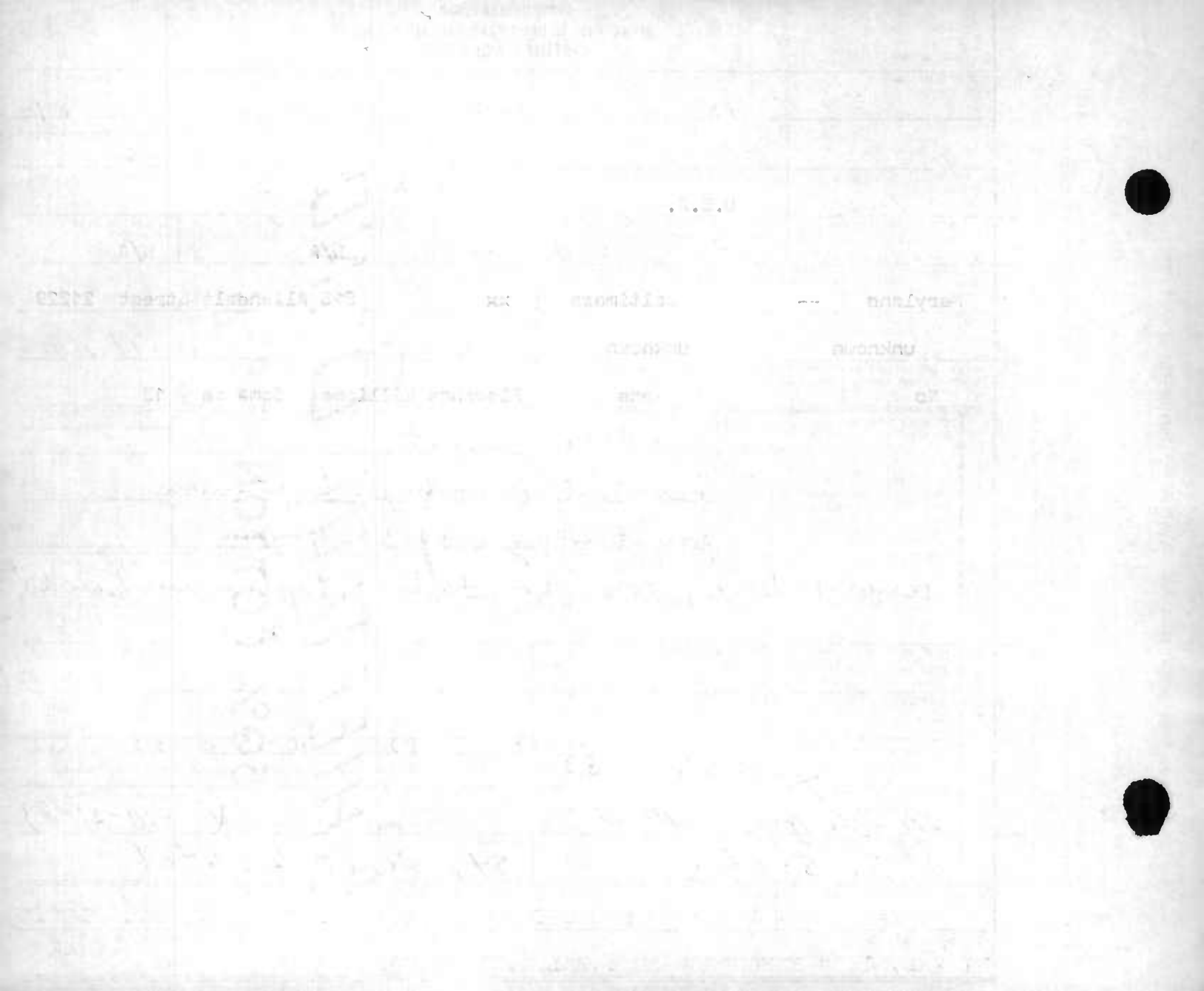
1214 GAYLAW PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without 73 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	2	7	1	7	1
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Baby Boy Williams</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>10-19-83</b>				2b. HOUR <b>3:30 PM</b>		
3. SEX <b>male</b>			4. RACE <b>Black</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>10-17-83</b>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2</b>			IF UNDER 1 YEAR HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN AUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>--</b> 13c. CITY OR TOWN <b>Baltimore</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>525 Allandale Street 21229</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE B WILLIAMS</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT ADDRESS <b>Florence Williams Same as # 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>7651</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cerebral hemorrhage + hypotension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>prematurity + perinatal asphyxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>renal failure, respiratory failure, hyaline membrane dis.</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>10-17</b> , 19 <b>83</b> , to <b>10-19</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-19</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>M. J. Scobie M.D.</b>										DEGREE		22c. DATE SIGNED <b>10-21-83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. J. Scobie</b>										22e. ADDRESS <b>St. Agnes Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/9/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL 4300</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>OLD FREDERICK RD. BALTO. MD</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>WITZKE, 1630 EDMONDSON AVE., BALTO. 21228</b>										25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gish</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carrie B Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 13 83</b>			2b. HOUR <b>1:50 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>510 N Gilman St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Williams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Winnie James</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>900-39-4407</b>		17. INFORMANT ADDRESS <b>MARY GLENN 510 N Gilman St</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST.</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRO VASCULAR ACCIDENT.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <b>PNEUMONIA.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>none</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>none</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>none</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>none</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>none</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-31-83</b> to <b>10-13-83</b> , that (I) (we) lost saw the deceased alive on <b>10-12-83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Surjit S. Tulka</b>						DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>10-13-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SURJIT S. TULKA</b>						22e. ADDRESS <b>BON SECOURS HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>			23b. DATE <b>10-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARY A. DUNN</b>		23d. LOCATION CITY OR TOWN STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>M. P. Dwyer, 6387 G. G. Rd. Sct</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carrick</b>		

BP



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James E. Williams

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James E. Williams

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Cezelle				Williams	10	17	83		130P
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Black	April 22, 1983					MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		United States				Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City		Baltimore City Hospital			N/A				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS		13f. ZIP CODE	
Maryland		Charles		Pisgah		Stuckey Road		20640	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Mark		E.		Coates		Suzette		Williams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
N/A					N/A		Suzette Williams P.O. Box 155 Pisgah, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopulmonary Dysplasia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Respiratory Distress Syndrome</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Perinatal</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Possible Sepsis / Seizure disorder, Encephalopathy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
A						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED			
NA		HOUR A.M. MONTH DAY YEAR		P.M. 19		NA			
21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN		COUNTY		STATE	
NA		STREET		NA					
22a. certify that (I) (this hospital) attended the deceased from <u>422 (Birth)</u> 19 <u>83</u> , to <u>10-17</u> 19 <u>83</u> , that (I) (we) lost									
saw the deceased alive on <u>10-17</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE									
DEGREE									
22c. DATE SIGNED									
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
E.L. BARTLETT, JR. MD. BALTIMORE CITY HOSP									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE	
Burial		10-21-83		St. Charles		Glymont		Charles Md.	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
Thornton Funeral Home					Pomonkey, Md.				
25b. REGISTRAR'S SIGNATURE					OCT 24 1983				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315

481/17-1-1

1. TITLE

2. AUTHOR

3. SUBJECT

4. ABSTRACT

5. SUMMARY

6. REFERENCES

7. NOTES

8. CONCLUSIONS

9. RECOMMENDATIONS

10. REFERENCES

11. NOTES

12. CONCLUSIONS

13. RECOMMENDATIONS

14. REFERENCES

15. NOTES

16. CONCLUSIONS

17. RECOMMENDATIONS

18. REFERENCES



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST LAST <b>EMMA L. WILLIAMS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10 25 1983</b>			2b. HOUR <b>11 A M</b>			
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 16 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSP.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1731 WENTWORTH RD 21234</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN R. WILLIAMS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA LORETTA REIPE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-12-4359</b>		17. INFORMANT ADDRESS <b>CHARLES WILLIAMS (HUSBAND) SAME</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>5715 IMMEDIATE CAUSE (a) CARDIAC ARREST, ETIOLOGY UNKNOWN</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BLEEDING ESOPHAGEAL VARICES, MASSIVE 12 HRS</b> (c) <b>CIRRHOSIS OF LIVER</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION <b>10/25/83</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MASSIVE UPPER GE BLEEDING</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>CARDIAC ARREST DURING SURGERY</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/21</b> , 19 <b>83</b> , to <b>10/25</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Artemio M. Cuevas Jr.</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/25/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTEMIO M. CUEVAS, JR.</b>					22e. ADDRESS <b>1900 E. NORTHERN PKWY, BALT. MD 21239</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>OCT. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>TIMONIUM, BALTO. CO., MD.</b>			
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME, INC. BALTO., MD. 21211</b>					ADDRESS <b>6500 YORK RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

TO: [Illegible]  
FROM: [Illegible]  
DATE: [Illegible]  
RE: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]

6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 7 1 7 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Evelyn P. Williams			2a. DATE OF DEATH MONTH DAY YEAR 10 25 83			2b. HOUR 1 50 AM				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 10 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 (RS.)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) United Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY r		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21223 104 N. Bentonsburg St.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry DAVIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RENA FARROW						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 14 2153		17. INFORMANT ADDRESS Lethia Burns 2101 Windsor Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO pulmonary arrest</u> 6869 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>necrotizing fasciitis @ thigh, groin</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <u>chronic renal, heart dx, history of heart block, angina</u>										
19a. DATE OF OPERATION 10/19/83 10/24/83 10/21/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (above)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Melvin J. Duckett</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/25/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Duckett, M.D.						22e. ADDRESS United Maryland Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/29/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR OCT 26 1983		
						25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>				

BP

20% COTTON FIBER

CHILMAM



MADE IN U.S.A.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Herman E. (M.) Williams								10 18 1983								3:32 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	9 11 24		59 YRS.						10 18 1983							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.				Baltimore City,											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		725 George Street, Apt. 13G															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		725 George Street Apt. 13G									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		219-18-7572		Janie Williams		725 George St. Apt 13G											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Larynx</u> 1619 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
<i>Dennis F. Smyth</i>		M.D. Assistant		10-19-83													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		10/24/83		Md. Veteran Cemetery		Crownsville, Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Wm C March F/H Inc. 1101 E. North Avenue		OCT 20 1983		<i>John J. Conner</i>													

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO.					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HOWARD H. WILLIAMS.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 11, 1983</b>				
SEX <b>Male.</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 9 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7b. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>-----</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Oil Heat.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Buena 3524 Buena Vista Ave. 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard H. Williams.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? ? ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W.W.11 212-07-2825</b>		17. INFORMANT ADDRESS <b>Dorothy M. Williams. 3524 Buena Vista Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Right Lung + Liver</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-28-83</b> to <b>October 11, 1983</b> , that (I) (we) last saw the deceased alive on <b>9-28-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Harold E. Ramsey, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD E. RAMSEY</b>						22e. ADDRESS <b>3100 WYMAN PARK DRIVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial.</b>		23b. DATE <b>Oct 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crownsville Veterans</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Paul E. Chenoweth</b>						ADDRESS <b>3615-19 Chestnut Ave.</b>		25. DATE REC'D. BY REGISTRAR <b>Oct 13 1983</b>	
						26. REGISTRAR'S SIGNATURE <b>John J. Galt</b>			

BP

October 11, 1963

William

H.

HOWARD

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Wife.

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D.A.

Id.

Truck Driver. 311 West.

Id.

3521 Green Vista Ave.

x

Id.

Id.

William

H.

HOWARD

512-07-2822

M.W.II

Yes

Howard H. Williams. 3521 Green Vista Ave.

*Interstate Commerce Commission*

20% COLLECT

22

Serial. Oct 11, 1963 Greenville Veteran, Greenville, Tenn.

Paul J. Greenwell 301-19 Chestnut Ave.

*James E. Kennedy*

*Sixty William Park Drive*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 7 1 7 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD Joseph WILLIAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/29/83</b>		2b. HOUR <b>11:17 P</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 19 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US of A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>HORSEMAN</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>✓</b>		
13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>2125 MT. HOLLY ST.</b>			13f. STREET ADDRESS <b>21216</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ENOCH WILLIAMS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMIE HOLLEY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES IF UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>231 07 7359</b>		
17. INFORMANT ADDRESS <b>MISS ELAINE C. SMITH 2125 MT. HOLLY STREET</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4920 Adult Respiratory Distress</b> IMMEDIATE CAUSE (a) <b>Adult Respiratory Distress</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gastric Carcinoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b> <b>2 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29</b> , 19 <b>83</b> , to <b>10/29</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Philip Konits</b>				22c. DATE SIGNED <b>10/30/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P Konits</b>				22e. ADDRESS <b>Lutheran Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VET. CEM.</b>	
23d. LOCATION <b>CROWNSVILLE (AA Co.) MD.</b>					
24. FUNERAL DIRECTOR NAME <b>LEWIS T. GWYNN</b> ADDRESS <b>4517 PARK HEIGHTS AVENUE</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 1 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>	



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5155 ST. HENRY ST. BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27179

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES O WILLIAMS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-18-83</b>		2b. HOUR <b>2 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>05 31 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		
7a. BIRTHPLACE (COUNTRY) <b>NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balt. City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Univ. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNEMPLOYED</b>		
12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>2014 ROBB ST</b>		21218						
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERNEST WILLIAMS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PEGGY SADLER ALSTON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>246-30-0493</b>		17. INFORMANT ADDRESS <b>Lillie Williams 2014 Robb Street</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> <b>1490</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic cancer of pharynx</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>								
19a. DATE OF OPERATION <b>1981</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of pharynx.</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> , 19 <b>83</b> , to <b>10-18</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Michael Moris</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10-18-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL MORIS</b>				22e. ADDRESS <b>UNIV. HOSP. ENT</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/22/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1983</b>				
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>				

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CHAMPAIN

20% COTTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Nathaniel Williams</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 83</b>			2b. HOUR <b>9 26 PM</b>			
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 4 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Columbia, S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lenman Inc.</b>	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Balto. Md. 21216 3510 Springdale Ave</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christine Williams</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>215-05-3868</b>		17. INFORMANT <b>Ida S. Williams</b>		ADDRESS <b>Baltimore, Md. 21216 3510 Springdale Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Oat Cell Carcinoma</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular Accident</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b; PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-8</b> 19 <b>83</b> , to <b>10-24</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10-24</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Jeffrey M. Moll MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>10/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey M. Moll MD</b>				22e. ADDRESS <b>SINAI HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Nutter &amp; Sons</b>				25. DATE REC'D. BY REGISTRAR <b>OCT 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lewis</b>			
NAME <b>Funeral Home Inc.</b>				ADDRESS <b>Pkwy. Balto. Md. 21216</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 3 2 7 1 8 1										
1. FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST					MONTH DAY YEAR HOUR					
SQUIRE T. WILLIAMS					10 23 83 630 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Male		Black		MONTH DAY YEAR		81 YRS.				
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, DC		U.S.A.				BALTIMORE CITY		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		PROVIDENT HOSPITAL								
13a. STATE					13b. COUNTY		13c. CITY OR TOWN			
Maryland							Baltimore			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST					FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO					216-01-0489		Hilda Branch 3327 Alto Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4/100										
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
22a. I certify that (I) (this hospital) attended the deceased from 10/23 1983, to 10/23 1983, that (I) (we) lost saw the deceased alive on 10/23 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
UDON OBIOTTA, MD					2600 LIBERTY HEIGHTS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL			10/28/83		Mount Auburn Cem.		Baltimore, COUNTY Md.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm C March F/H Inc. 1101 E North Avenue					OCT 26 1983		John J. Carver			

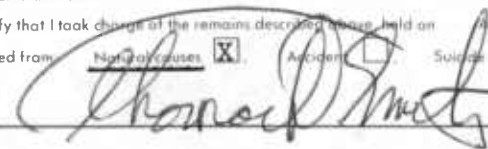

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544

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27182	
1. DECEASED NAME (TYPE OR PRINT) <b>Carey (Carry) Willis</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 18 19 83</b>		2b. HOUR <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 10 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>10 18 19 83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>524 E. 23rd Street</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>524 E. 23th Street 21218</b>			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>213-07-9742</b>		17. INFORMANT ADDRESS <b>Barbara Smith 10 Bishopgate Court</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described herein, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy Chief</b> MEDICAL EXAMINER				DATE SIGNED <b>10/18/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>10/22/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1983</b>		25b. REGISTRAR'S SIGNATURE 			

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.

241



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
DELORES F. WILSON								10 28 83	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		BLACK		9 28 32		51		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
BALTIMORE MD		USA				BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		4008 BONNER ROAD				CLERK - U.S. Gov't			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD				BALTIMORE				4008 BONNER ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Pete BROWN		LENA BROWN		NO					
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
		FRANIS WILSON		3112 WILCOX AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung with 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF cerebral metastases (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 1983 to October 28, 1983, that (I) (we) last saw the deceased alive on October 17, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Marshall A. Levine MD						10/28/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Marshall A. Levine		711 W. 40th St Baltimore, MD, 21211							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		11-1-83		BETHURUS MEM. PT		BALTIMORE MD 21217			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Marshall P. Hayne		OCT 31 1983		John J. Conner					

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Report of the

Commissioner of Plant Industry

for the year ending June 30, 1911

Presented to the Congress of the United States

at its session at Washington, D. C.

January 1912

Published by the Government Printing Office

Washington, D. C.

1912

Price 10 cents

For sale by the Superintendent of Documents

Washington, D. C.

1912

Price 10 cents

For sale by the Superintendent of Documents

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1912

Price 10 cents

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TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

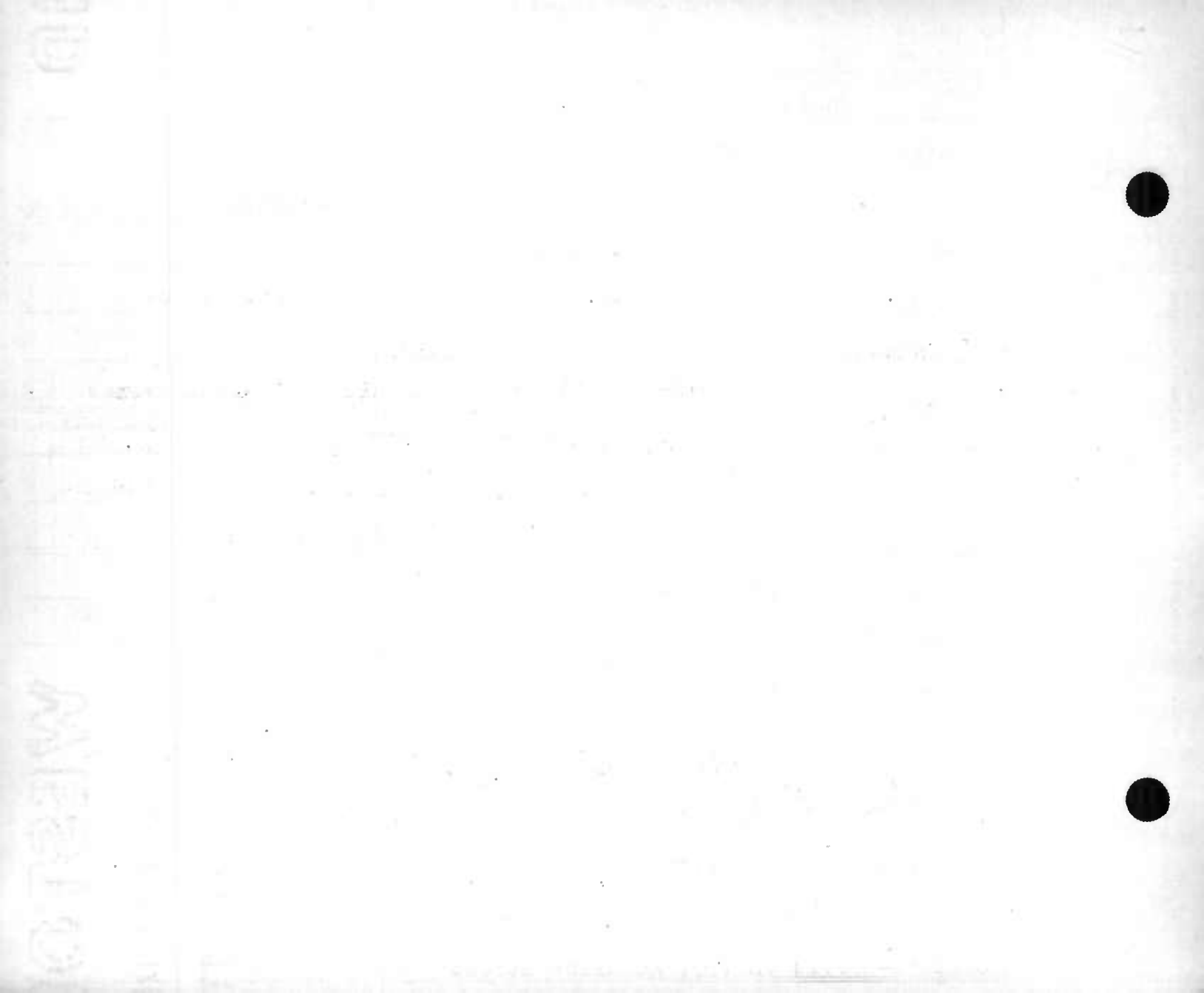
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eddie Wilson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 24 83</b>			2b. HOUR M <b>AM</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 6 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2607 List Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2607 List Avenue 21214</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>212-12-5284</b>		17. INFORMANT ADDRESS <b>Curtis McDaniel 2607 List Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediately</b> <b>10 yrs</b> <b>10 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 19 83</b> to <b>10/24 19 83</b> , that (we) lost saw the deceased alive <b>10/23 19 83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stanley D. Madson MD</b> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.D. Madson, MD</b>					22e. ADDRESS <b>5428 Sinclair Lane Baltimore Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chatman-Harris FH 1701 McCulloh Street</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 31 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

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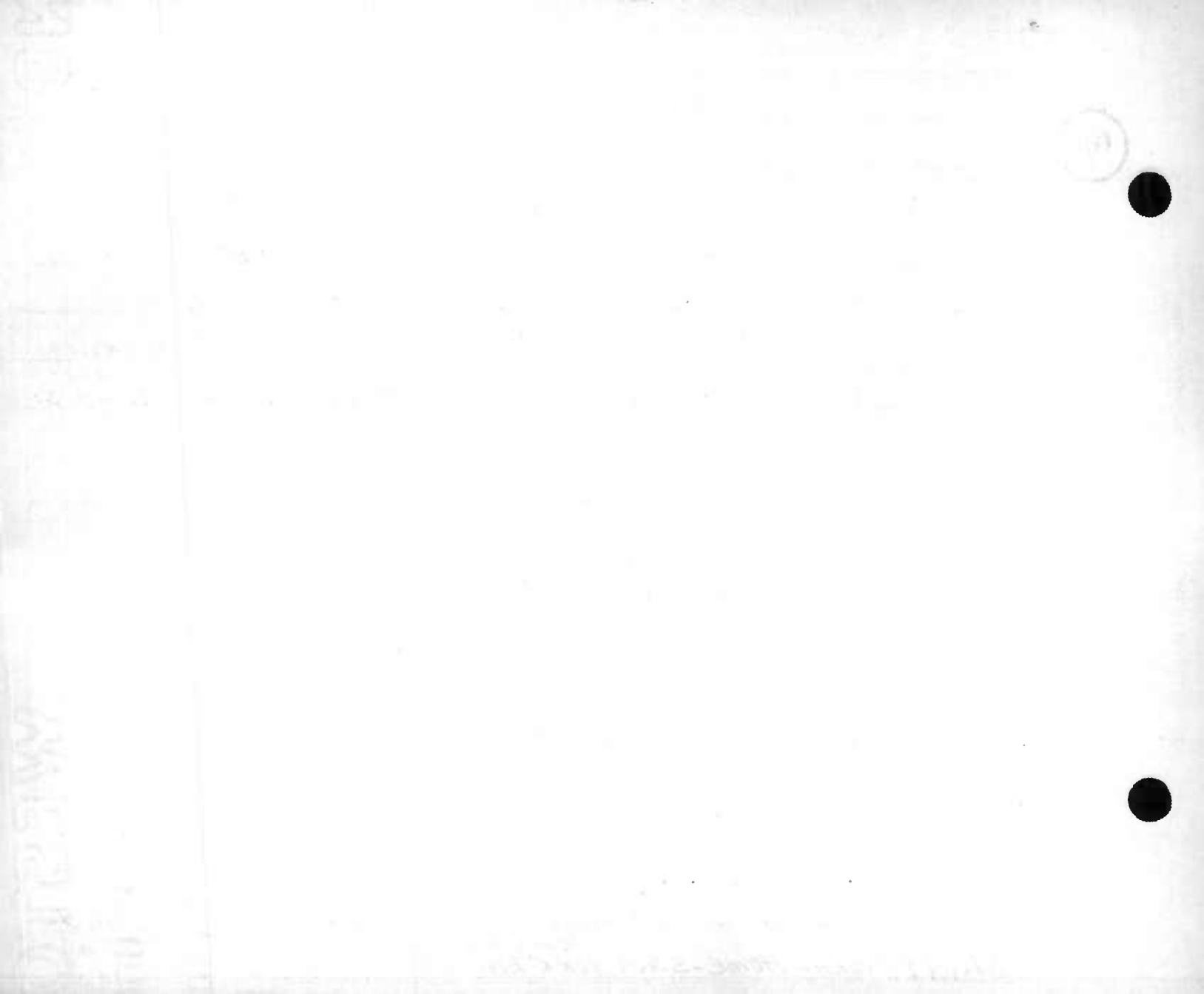


TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 27185			
FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) HATTIE B. WILSON				2a. DATE OF DEATH MONTH DAY YEAR OCT 30 1983		2b. HOUR 12:30 <sup>PM</sup>	
3 SEX FEMALE		4 RACE NEGRO		5 DATE OF BIRTH MONTH DAY YEAR 03 28 1905		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIMLICO MANOR NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND				13b COUNTY BALTIMORE		13c STREET ADDRESS 1502 EDISON HIGHWAY 21213	
14 FATHER'S NAME FIRST MIDDLE LAST ? ? ?				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA JENKINS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 015-26-2719		17 INFORMANT ADDRESS MRS. ROXIE HARRIS - 1504 N. BOND ST. 21213	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FEVER AND SEPSIS 0389 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): DIABETES MELLITUS, CVA, DECUBITUS ULCER							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) <del>XXXXXX</del> attended the deceased from 09-29 1983, to 10-30 1983, that (we) last saw the deceased alive on 10-30-1983, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>XXXXXX</del> did not view the body after death.							
22b SIGNATURE <i>Debesius</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-30-83	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR M. LEBSON, M.D.				22e ADDRESS 3640 FORDS LANE BALTIMORE 21215			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11-2-83		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24 FUNERAL DIRECTOR NAME REDD FUNERAL HOME - 5209 YORK RD.				ADDRESS BALTO. MD.		25a DATE REC'D. BY REGISTRAR NOV 7 1983	
				25b REGISTRAR'S SIGNATURE <i>John J. Conner</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WILLIAM WILSON JR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10 28 83</b>			2b. HOUR M <b>0:45 am</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 21 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>warehouse worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHEET METAL COATING &amp; LITHO. CO.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN WILLIAM WILSON SR.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLAIRE A. WERNER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>DOROTHY E. WILSON 2531 TOLLEY STREET, 21230</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTRACRANIAL HAEMORRHAGE,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONITIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>---</b>										
19a. DATE OF OPERATION <b>---</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> <b>---</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>---</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b> <b>---</b> <b>---</b> <b>---</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/07</b> , 19 <b>83</b> , to <b>10/28</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10/28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>K T SHAW</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/28/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K T SHAW</b>					22e. ADDRESS <b>ST. AGNES HOSPITAL, BALTIMORE, MD 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10-31-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 31 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lindsay</u> <u>Wilson</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10-8-83</u>			2b. HOUR <u>8:55 AM</u>	
3. SEX <u>M</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3</u> <u>1</u> <u>20</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>S.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wyman Park Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>merchant marine</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>city</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Emm</u> <u>st</u> <u>Wilson</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Beulah</u> <u>Wilson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>1941-1945</u>		17. INFORMANT <u>James Wilson</u>		ADDRESS <u>1310 Edgewood Rd.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest  
1850  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Prostatic cancer  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>82</u> , to <u>10/8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>10/8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <u>Linger</u>				DEGREE <u>MO</u>		22c. DATE SIGNED <u>10/1/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William A. Levinger</u>				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>10-14-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CROWNsville Vet. CROWNsville A.A.O.M.D.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>BROWN-Thompson F.H.</u>				25. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			
ADDRESS <u>1913 W. BALTO ST.</u>				OCT 10 1983			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MATTHEW Augustus WILSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-20-83</b>			2b. HOUR <b>7.30AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>21</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Penna</b>					13b. COUNTY <b>York</b>		13c. CITY OR TOWN <b>Delta</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Terry Wilson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbra J. Scheiler</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Terry Wilson, R.D.1, Delta, PA 17314</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b> <b>7718</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SHOCK (HYPOTENSION)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>SEPSIS; MIBNINGITIS (E. COLI)</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PERMUTURITY; PROLONGED RUPTURE OF MEMBRANES</b>										
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> <b>NO</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NA</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <b>NA</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) <b>NA</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>9-30</b> 19 <b>83</b> to <b>10-20</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10-19</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Barbra J. Scheiler MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-20-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. BARTLETT SR MD</b>			22e. ADDRESS <b>BALTIMORE CITY HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Oct. 22, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Delta York Penna.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Harkins, 600 Main Street, Delta, PA</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1915-16	1916-17	1917-18	1918-19	1919-20	1920-21	1921-22	1922-23	1923-24	1924-25	1925-26	1926-27	1927-28	1928-29	1929-30	1930-31	1931-32	1932-33	1933-34	1934-35	1935-36	1936-37	1937-38	1938-39	1939-40	1940-41	1941-42	1942-43	1943-44	1944-45	1945-46	1946-47	1947-48	1948-49	1949-50	1950-51	1951-52	1952-53	1953-54	1954-55	1955-56	1956-57	1957-58	1958-59	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33	2033-34	2034-35	2035-36	2036-37	2037-38	2038-39	2039-40	2040-41	2041-42	2042-43	2043-44	2044-45	2045-46	2046-47	2047-48	2048-49	2049-50	2050-51	2051-52	2052-53	2053-54	2054-55	2055-56	2056-57	2057-58	2058-59	2059-60	2060-61	2061-62	2062-63	2063-64	2064-65	2065-66	2066-67	2067-68	2068-69	2069-70	2070-71	2071-72	2072-73	2073-74	2074-75	2075-76	2076-77	2077-78	2078-79	2079-80	2080-81	2081-82	2082-83	2083-84	2084-85	2085-86	2086-87	2087-88	2088-89	2089-90	2090-91	2091-92	2092-93	2093-94	2094-95	2095-96	2096-97	2097-98	2098-99	2099-00	2100-01	2101-02	2102-03	2103-04	2104-05	2105-06	2106-07	2107-08	2108-09	2109-10	2110-11	2111-12	2112-13	2113-14	2114-15	2115-16	2116-17	2117-18	2118-19	2119-20	2120-21	2121-22	2122-23	2123-24	2124-25	2125-26	2126-27	2127-28	2128-29	2129-30	2130-31	2131-32	2132-33	2133-34	2134-35	2135-36	2136-37	2137-38	2138-39	2139-40	2140-41	2141-42	2142-43	2143-44	2144-45	2145-46	2146-47	2147-48	2148-49	2149-50	2150-51	2151-52	2152-53	2153-54	2154-55	2155-56	2156-57	2157-58	2158-59	2159-60	2160-61	2161-62	2162-63	2163-64	2164-65	2165-66	2166-67	2167-68	2168-69	2169-70	2170-71	2171-72	2172-73	2173-74	2174-75	2175-76	2176-77	2177-78	2178-79	2179-80	2180-81	2181-82	2182-83	2183-84	2184-85	2185-86	2186-87	2187-88	2188-89	2189-90	2190-91	2191-92	2192-93	2193-94	2194-95	2195-96	2196-97	2197-98	2198-99	2199-00	2200-01	2201-02	2202-03	2203-04	2204-05	2205-06	2206-07	2207-08	2208-09	2209-10	2210-11	2211-12	2212-13	2213-14	2214-15	2215-16	2216-17	2217-18	2218-19	2219-20	2220-21	2221-22	2222-23	2223-24	2224-25	2225-26	2226-27	2227-28	2228-29	2229-30	2230-31	2231-32	2232-33	2233-34	2234-35	2235-36	2236-37	2237-38	2238-39	2239-40	2240-41	2241-42	2242-43	2243-44	2244-45	2245-46	2246-47	2247-48	2248-49	2249-50	2250-51	2251-52	2252-53	2253-54	2254-55	2255-56	2256-57	2257-58	2258-59	2259-60	2260-61	2261-62	2262-63	2263-64	2264-65	2265-66	2266-67	2267-68	2268-69	2269-70	2270-71	2271-72	2272-73	2273-74	2274-75	2275-76	2276-77	2277-78	2278-79	2279-80	2280-81	2281-82	2282-83	2283-84	2284-85	2285-86	2286-87	2287-88	2288-89	2289-90	2290-91	2291-92	2292-93	2293-94	2294-95	2295-96	2296-97	2297-98	2298-99	2299-00	2300-01	2301-02	2302-03	2303-04	2304-05	2305-06	2306-07	2307-08	2308-09	2309-10	2310-11	2311-12	2312-13	2313-14	2314-15	2315-16	2316-17	2317-18	2318-19	2319-20	2320-21	2321-22	2322-23	2323-24	2324-25	2325-26	2326-27	2327-28	2328-29	2329-30	2330-31	2331-32	2332-33	2333-34	2334-35	2335-36	2336-37	2337-38	2338-39	2339-40	2340-41	2341-42	2342-43	2343-44	2344-45	2345-46	2346-47	2347-48	2348-49	2349-50	2350-51	2351-52	2352-53	2353-54	2354-55	2355-56	2356-57	2357-58	2358-59	2359-60	2360-61	2361-62	2362-63	2363-64	2364-65	2365-66	2366-67	2367-68	2368-69	2369-70	2370-71	2371-72	2372-73	2373-74	2374-75	2375-76	2376-77	2377-78	2378-79	2379-80	2380-81	2381-82	2382-83	2383-84	2384-85	2385-86	2386-87	2387-88	2388-89	2389-90	2390-91	2391-92	2392-93	2393-94	2394-95	2395-96	2396-97	2397-98	2398-99	2399-00	2400-01	2401-02	2402-03	2403-04	2404-05	2405-06	2406-07	2407-08	2408-09	2409-10	2410-11	2411-12	2412-13	2413-14	2414-15	2415-16	2416-17	2417-18	2418-19	2419-20	2420-21	2421-22	2422-23	2423-24	2424-25	2425-26	2426-27	2427-28	2428-29	2429-30	2430-31	2431-32	2432-33	2433-34	2434-35	2435-36	2436-37	2437-38	2438-39	2439-40	2440-41	2441-42	2442-43	2443-44	2444-45	2445-46	2446-47	2447-48	2448-49	2449-50	2450-51	2451-52	2452-53	2453-54	2454-55	2455-56	2456-57	2457-58	2458-59	2459-60	2460-61	2461-62	2462-63	2463-64	2464-65	2465-66	2466-67	2467-68	2468-69	2469-70	2470-71	2471-72	2472-73	2473-74	2474-75	2475-76	2476-77	2477-78	2478-79	2479-80	2480-81	2481-82	2482-83	2483-84	2484-85	2485-86	2486-87	2487-88	2488-89	2489-90	2490-91	2491-92	2492-93	2493-94	2494-95	2495-96	2496-97	2497-98	2498-99	2499-00	2500-01	2501-02	2502-03	2503-04	2504-05	2505-06	2506-07	2507-08	2508-09	2509-10	2510-11	2511-12	2512-13	2513-14	2514-15	2515-16	2516-17	2517-18	2518-19	2519-20	2520-21	2521-22	2522-23	2523-24	2524-25	2525-26	2526-27	2527-28	2528-29	2529-30	2530-31	2531-32	2532-33	2533-34	2534-35	2535-36	2536-37	2537-38	2538-39	2539-40	2540-41	2541-42	2542-43	2543-44	2544-45	2545-46	2546-47	2547-48	2548-49	2549-50	2550-51	2551-52	2552-53	2553-54	2554-55	2555-56	2556-57	2557-58	2558-59	2559-60	2560-61	2561-62	2562-63	2563-64	2564-65	2565-66	2566-67	2567-68	2568-69	2569-70	2570-71	2571-72	2572-73	2573-74	2574-75	2575-76	2576-77	2577-78	2578-79	2579-80	2580-81	2581-82	2582-83	2583-84	2584-85	2585-86	2586-87	2587-88	2588-89	2589-90	2590-91	2591-92	2592-93	2593-94	2594-95	2595-96	2596-97	2597-98	2598-99	2599-00	2600-01	2601-02	2602-03	2603-04	2604-05	2605-06	2606-07	2607-08	2608-09	2609-10	2610-11	2611-12	2612-13	2613-14	2614-15	2615-16	2616-17	2617-18	2618-19	2619-20	2620-21	2621-22	2622-23	2623-24	2624-25	2625-26	2626-27	2627-28	2628-29	2629-30	2630-31	2631-32	2632-33	2633-34	2634-35	2635-36	2636-37	2637-38	2638-39	2639-40	2640-41	2641-42	2642-43	2643-44	2644-45	2645-46	2646-47	2647-48	2648-49	2649-50	2650-51	2651-52	2652-53	2653-54	2654-55	2655-56	2656-57	2657-58	2658-59	2659-60	2660-61	2661-62	2662-63	2663-64	2664-65	2665-66	2666-67	2667-68	2668-69	2669-70	2670-71	2671-72	2672-73	2673-74	2674-75	2675-76	2676-77	2677-78	2678-79	2679-80	2680-81	2681-82	2682-83	2683-84	2684-85	2685-86	2686-87	2687-88	2688-89	2689-90	2690-91	2691-92	2692-93	2693-94	2694-95	2695-96	2696-97	2697-98	2698-99	2699-00	2700-01	2701-02	2702-03	2703-04	2704-05	2705-06	2706-07	2707-08	2708-09	2709-10	2710-11	2711-12	2712-13	2713-14	2714-15	2715-16	2716-17	2717-18	2718-19	2719-20	2720-21	2721-22	2722-23	2723-24	2724-25	2725-26	2726-27	2727-28	2728-29	2729-30	2730-31	2731-32	2732-33	2733-34	2734-35	2735-36	2736-37	2737-38	2738-39	2739-40	2740-41	2741-42	2742-43	2743-44	2744-45	2745-46	2746-47	2747-48	2748-49	2749-50	2750-51	2751-52	2752-53	2753-54	2754-55	2755-56	2756-57	2757-58	2758-59	2759-60	2760-61	2761-62	2762-63	2763-64	2764-65	2765-66	2766-67	2767-68	2768-69	2769-70	2770-71	2771-72	2772-73	2773-74	2774-75	2775-76	2776-77	2777-78	2778-79	2779-80	2780-81	2781-82	2782-83	2783-84	2784-85	2785-86	2786-87	2787-88	2788-89	2789-90	2790-91	2791-92	2792-93	2793-94	2794-95	2795-96	2796-97	2797-98	2798-99	2799-00	2800-01	2801-02	2802-03	2803-04	2804-05	2805-06	2806-07	2807-08	2808-09	2809-10	2810-11	2811-12	2812-13	2813-14	2814-15	2815-16	2816-17	2817-18	2818-19	2819-20	2820-21	2821-22	2822-23	2823-24	2824-25	2825-26	2826-27	2827-28	2828-29	2829-30	2830-31	2831-32	2832-33	2833-34	2834-35	2835-36	2836-37	2837-38	2838-39	2839-40	2840-41	2841-42	2842-43	2843-44	2844-45	2845-46	2846-47	2847-48	2848-49	2849-50	2850-51	2851-52	2852-53	2853-54	2854-55	2855-56	2856-57	2857-58	2858-59	2859-60	2860-61	2861-62	2862-63	2863-64	2864-65	2865-66	2866-67	2867-68	2868-69	2869-70	2870-71	2871-72	2872-73	2873-74	2874-75	2875-76	2876-77	2877-78	2878-79	2879-80	2880-81	2881-82	2882-83	2883-84	2884-85	2885-86	2886-87	2887-88	2888-89	2889-90	2890-91	2891-92	2892-93	2893-94	2894-95	2895-96	2896-97	2897-98	2898-99	2899-00	2900-01	2901-02	2902-03	2903-04	2904-05	2905-06	2906-07	2907-08	2908-09	2909-10	2910-11	2911-12	2912-13	2913-14	2914-15	2915-16	2916-17	2917-18	2918-19	2919-20	2920-21	2921-22	2922-23	2923-24	2924-25	2925-26	2926-27	2927-28	2928-29	2929-30	2930-31	2931-32	2932-33	2933-34	2934-35	2935-36	2936-37	2937-38	2938-39	293
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 77 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "18 shows any injury, or other traumatic event, the medical examiner must be notified at once."

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Mary Ann Wilson								October 1, 1983		8:10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH DAY YEAR 1 13 19		64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Delaware		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		629 South Umbra Street						Housework		At Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland				Baltimore						629 S. Umbra Street 21224	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Leroy Fleming		FIRST MIDDLE LAST Mattie Mulligan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
No		221-09-7407		Frank W. Wilson 629 S. Umbra Street 21224							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC COLONIC CANCER</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> , 19 <u>83</u> , to <u>10/13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
DEBRA S WERTHEIMER		MD						10/3/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DEBRA S WERTHEIMER		5200									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		10-4-83		Oak Lawn Cemetery		Eastwood, Balto. Co., Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles S. Zeiler & Son Inc.		6224 Eastern Ave.		OCT 3 1983		John J. Wilson					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.				8 3 2 7 1 9 0				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGIL S WILSON					2a. DATE OF DEATH MONTH DAY YEAR 10/18/83					2b. HOUR 5:27 P.M.
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/14/20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COMMUNICATIONS		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. COUNTY BALTO		13d. CITY OR TOWN ESSEX		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS 19 ORVILLE RD. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC WILSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH E. STANLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II				16b. SOCIAL SECURITY NO. 232 42 5974		17. INFORMANT ADDRESS GRACE WILSON ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>History of arrhythmias</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from 10/18/83 to 10/18/83, that (I) we saw the deceased alive on 10/18/83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.										
22b. SIGNATURE Daniel M. Perlman				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/18/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. PERLMAN				22e. ADDRESS Baltimore City Hospitals Balto. 21224						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/22/83		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD				
24. FUNERAL DIRECTOR NAME J. G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR OCT 20 1983		25b. REGISTRAR'S SIGNATURE Joan J. Connelly		

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10/18/83

WILSON

VIRGIL

Baltimore City

CARDIO-RESPIRATORY / WEST

CHRONIC KIDNEY FAILURE

History of angina pectoris

10/18/83

10/18/83

Dr. [illegible] Baltimore City Hospital

10/18/83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ETHEL W. WINCHESTER			2a. DATE OF DEATH MONTH DAY YEAR 10 22 83			2b. HOUR M AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3615 Brooklyn Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Winchester		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Krach		13e. STREET ADDRESS 3615 Brooklyn Ave. (21225)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 09 0683		17. INFORMANT ADDRESS Anne Dahler (same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years 6 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bronchiectasis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 19 <u>73</u> , to <u>22-Oct</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>14-Oct</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Richard E. Fisher</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Fisher				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 24 Oct 83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/83		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Maryland		
24. FUNERAL DIRECTOR NAME George J. Gonce 4001 Ritchie Hwy				25a. DATE REC'D. BY REGISTRAR OCT 24 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-2660.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>LEWIS E. WINDSOR</b>									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>LEWIS EMERSON WINDSOR</b>						2a. DATE OF DEATH MONTH <b>10</b> DAY <b>16</b> YEAR <b>83</b> 2b. HOUR <b>12:20<sup>P</sup></b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>26</b> YEAR <b>12</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>70</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTIMORE GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MILL FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>603 PONTIAC AVE (26225)</b>			
14. FATHER'S NAME FIRST <b>LEWIS</b> MIDDLE <b>WINDSOR</b> LAST <b>LEWIS</b>				15. MOTHER'S MAIDEN NAME FIRST <b>EFFIE</b> MIDDLE <b>KELLY</b> LAST <b>KELLY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>RUTH WINDSOR (SAME AS 13c)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>2060</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MONOCYTIC LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LEUKEMIC MENINGITIS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>8/9</b> , 19 <b>83</b> , to <b>10/16</b> , 19 <b>83</b> , that (we) last saw the deceased alive on <b>10/16</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. H. BAKER</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/16/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. H. BAKER</b>				22e. ADDRESS <b>3001 S. BALTIMORE HANOVER ST</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>10/18/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>			
24. FUNERAL DIRECTOR NAME <b>BALTO., MD. 21225</b> <b>GEORGE J. GONCE F.H. 4001 RITCHIE HWY.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Casper</b>			

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MARYLAND	BALTIMORE	CONSTITUTION AVE (3025)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the death certificate. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition. The death certificate must be notified of once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY</b>					2. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 10, 1983</b>					3. HOUR <b>8:42A</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 28 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3223 Cherrylane Road 21225</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elroy Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Johnson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-26-6597</b>		17. INFORMANT ADDRESS <b>Patricia Dunn 6129 64th Street</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>5679</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gram Negative Bacterial Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Spontaneous Bacterial Peritonitis</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 7</b> 19 <b>83</b> , to <b>OCT 10</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>OCT 10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Kevin J. Twohig</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kevin J. Twohig</b>						22e. ADDRESS <b>Johns Hopkins Hospital, Dept. of Medicine</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1983</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		
ADDRESS <b>1101 E North Avenue</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 7 1 9 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE WINSTON</b>				2a. DATE OF DEATH MONTH <b>10</b> DAY <b>2</b> YEAR <b>83</b>		2b. HOUR <b>4 45</b> <sup>AM</sup>	
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>11</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS <b>607 Pa. Ave. 21201</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>911-23-3228</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>83</b> , to <b>10/2</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nisha Soprey</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NISHA SOPREY</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>10/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>	

BP

20% COLL

CHIEF

10/2/93  
Bureau

Bureau

911-13-1118

607 E. Ave.

22201

Bureau

XX

U.S.

Harvard

Bureau

Providence





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0081 SS 1909

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MEMOR

NAME

US of A

ADMINISTR

ASSURANCE

RETIRED

51216

3317 WINDSOR AVENUE

X

BALTIMORE

WATKINS

PROVID

AMERICA

WISCONSIN

NEW YORK

NEW YORK

51216

3301 3001 MR. HENRY T. WISE 3317 WINDSOR AVENUE

NO

X

(AA Co.) MD.

BALTIMORE

CEDAR HILL COUNTRY

11/4/53

BUILD

LEWIS T. CHASE 4517 ELM STREET AVENUE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MARGARET Anna WOHLFORT					OCTOBER 17 83	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		2b. HOUR A. M.
Female		White		12 23 96		7:00 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS
Maryland		U.S.A.		86		IF UNDER 24 HRS. HOURS MIN.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore		Church Hospital		Baltimore City MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		
Retired		Housework		325 South Robinson St. 21224		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland				Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
John Betz			Margaret Mueller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		214-74-6914		Henry J. Wohlfort 3213 Fleet Street 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL BOWEL OBSTRUCTION						1 WEEK
5609 XXX						
DUE TO, OR AS A CONSEQUENCE OF (b)						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE: SEVERE DEPRESSION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER, 17 19 83 to OCTOBER, 17 19 83, that (I) (we) lost						
saw the deceased alive on OCTOBER, 17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE				22c. DATE SIGNED		
PAUL GORMLEY M.D.				10/17/83		
23a. PHYSICIAN'S NAME (TYPE OR PRINT)				22a. ADDRESS		
PAUL GORMLEY M.D.				BALTIMORE, MARYLAND 21231		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		
Burial				10-20-83		
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE		
Holy Redeemer Cem.				Baltimore City, Md.		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		
Charles S. Zeiler & Son Inc.				OCT 18 1983		
25b. REGISTRAR'S SIGNATURE						
John J. Canish						

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100



20% COTTON



10-20-23  
 10-20-23  
 10-20-23

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie R Womack			2a. DATE OF DEATH MONTH DAY YEAR 10-5-83			2b. HOUR 10 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4129 Fairview Ave. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Forrest			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 16 6008		17. INFORMANT ADDRESS Ronald C. Chester 1101 Wicklow Rd. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Advanced adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (b) of ovary with metas- DUE TO, OR AS A CONSEQUENCE OF (c) tasis.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from 9-6-1983, to 10-5-1983, that (if (we) last saw the deceased alive on 10-5-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE H. Devadoss				DEGREE MD.		22c. DATE SIGNED 10-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss				22e. ADDRESS Provident Hospital.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/11/83		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Nutter and Sons Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 10 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Marie L. Wouson</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10/21/83</i> 2b. HOUR <i>11:35AM</i>	
3. SEX <i>F</i>	4. RACE <i>B</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 30 16</i> 6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
10. CITY OR TOWN OF DEATH <i>BA40.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MERCY HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE <i>Maryland</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS <i>2647 Lauretta Avenue 21223</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Willie Lewis</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eular Lewis</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <i>578-22-2113</i>	
17. INFORMANT ADDRESS <i>Phyllis Sciver 1718 E. Lamont Avenue</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>12/18</i> 19 <i>82</i> , to <i>10/21</i> 19 <i>83</i> , that (we) last saw the deceased alive on <i>10/21</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Lawrence Blot MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/21/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LAURENCE BLOT</i>		22e. ADDRESS <i>333 ST PAUL PL. BALTO MD</i>	
23a. BURIAL, CREMATION, REMOVAL (SP) <i>BURIAL</i>		23b. DATE <i>10/25/83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus MemorialPk</i>
23d. LOCATION <i>Arbutus</i> COUNTY <i>Md.</i> STATE			
24. FUNERAL DIRECTOR NAME <i>Wm C March F/H Inc. 1101 E North Avenue</i> ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>OCT 24 1983</i> 25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>	



20% COTTON  
WHITE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27199	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>LOUIS WOODCOCK, JR.</b>										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>10-16-83</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 51</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>32 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>10-16-83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3455 Cottage Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>										13b. COUNTY	
13c. CITY OR TOWN <b>Baltimore</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3455 Cottage Avenue</b>										21215	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Woodcock, Sr.</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Mae Ames</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-60-3004</b>		17. INFORMANT ADDRESS <b>Lucy Woodcock 3455 Cottage Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4029</b> IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>10-17-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>10/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial PK.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Ave</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 18 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Gahring</i>			

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Page 1 of 1



9487 700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDGAR LESTER WOODEN</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>10 12 83 2 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>310 N. Culver Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tile Setter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wooden</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Jones</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-03-3598</b>		17. INFORMANT ADDRESS <b>Bessie N. Wooden 310 N. Culver St. 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4912 Impurely Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1973</b> , 19____, to <b>Feb</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>Feb</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James E. J. Hopkins M.D. M.D. PH.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/14/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Hopkins M.D.</b>				22e. ADDRESS <b>205 W. Lanvale Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/15/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Connelley</b>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 27201

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Addie B. Wright</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 27 83</b>			2b. HOUR <b>855 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 18 33</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mutree Lucky</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Boone</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>250-52-5409</b>		17. INFORMANT ADDRESS <b>Fennie Wright, Sr. 2412 Liberty Hgts.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>EMO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>INTRACRANIAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>J. Taylor</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/27</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jimmy TAYLOR</b>				22e. ADDRESS <b>2600 LIBERTY HEIGHTS AVE.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/1/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Anne Arundel Co, Md</b>	
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24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North avenue</b>		25a. DATE REC'D BY REGISTRAR <b>OCT 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 11 1900

NAME		AGE	SEX	RELATION	DATE
J. H. Smith		45	M	Head	1900
Mary Smith		40	F	Wife	1900
John Smith		15	M	Son	1900
Sarah Smith		12	F	Daughter	1900
James Smith		10	M	Son	1900
Elizabeth Smith		8	F	Daughter	1900
William Smith		5	M	Son	1900
Anna Smith		3	F	Daughter	1900
George Smith		2	M	Son	1900
Mary Smith		1	F	Daughter	1900

George Smith  
1900

NAME		AGE	SEX	RELATION	DATE
J. H. Smith		45	M	Head	1900
Mary Smith		40	F	Wife	1900
John Smith		15	M	Son	1900
Sarah Smith		12	F	Daughter	1900
James Smith		10	M	Son	1900
Elizabeth Smith		8	F	Daughter	1900
William Smith		5	M	Son	1900
Anna Smith		3	F	Daughter	1900
George Smith		2	M	Son	1900
Mary Smith		1	F	Daughter	1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEO WRIGHT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 23, 1983</b>			2b. HOUR <b>9:29P M</b>					
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 24 16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1807 E. Eager Street 21205</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wright</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Gibson</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>218-07-8693</b>		17. INFORMANT ADDRESS <b>A Vera Wright 1807 E. Eager Street</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> <b>4130</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>organic heart disease w/angina &amp; CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>0</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>10/26</b> , 19 <b>81</b> , to <b>7/15</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>7/15</b> , 19 <b>83</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>A. Schroeder</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10/24/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR Schroeder</b>			22e. ADDRESS <b>1000 E. Eager St. Balto Md</b>								
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>10/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc, 1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

RELEASED NON-MED DR KORELL PER MR PURVIS

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may also be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove card 4 from this certificate and send it to the funeral director, page 4 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be required of office.

CCC:10

RECEIVED

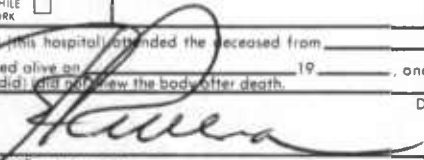
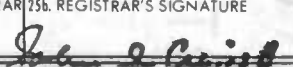
20% OFF



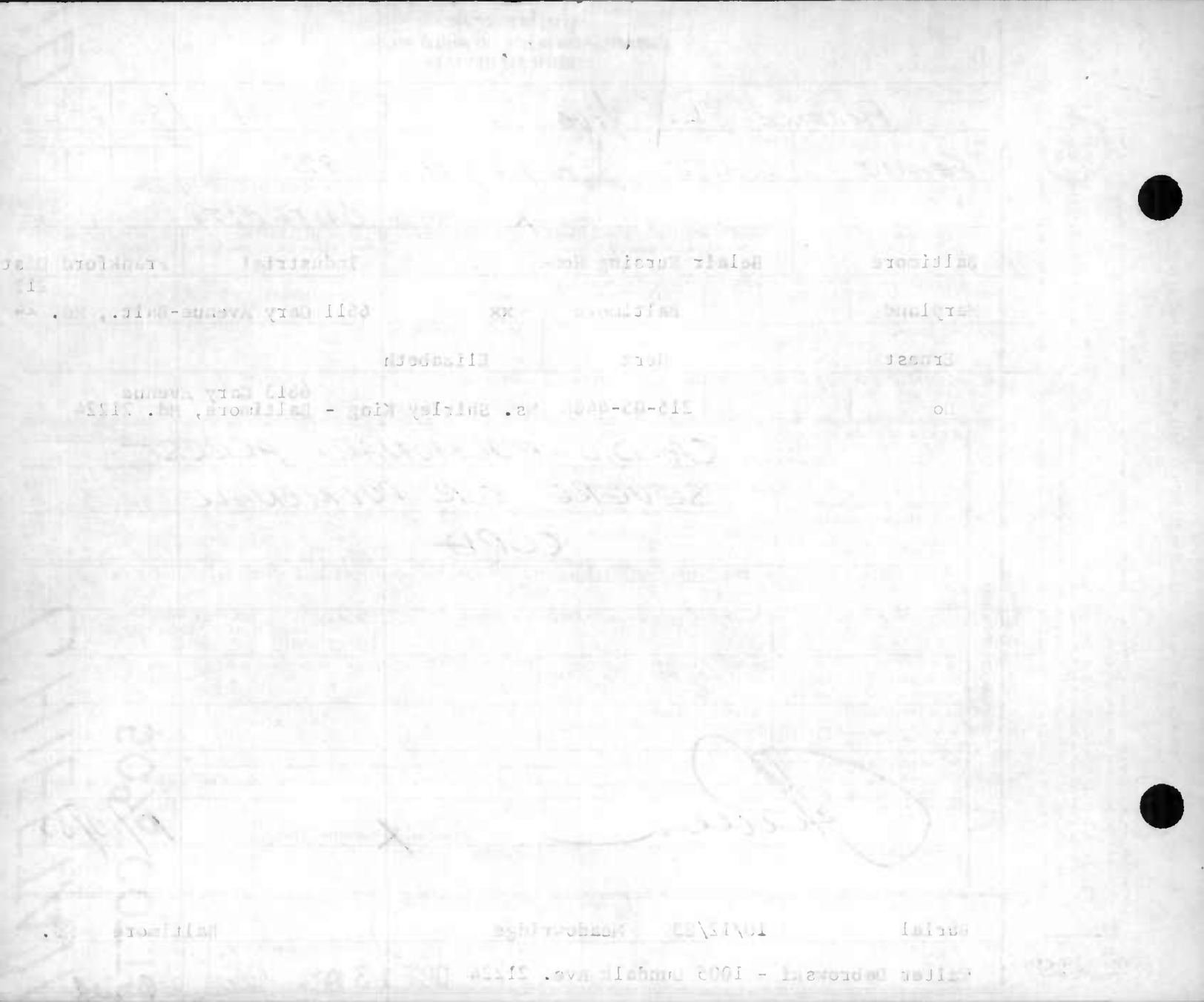
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 2 7 2 0 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE L. YINGLING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/10/83</b>		2b. HOUR <b>6<sup>55</sup> A.M.</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/6/01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Industrial</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Frankford Dist</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>6611 Gary Avenue-Balt., Md. 21224</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Herz</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-05-4468</b>		17. INFORMANT ADDRESS <b>6613 Gary Avenue</b> <b>Ms. Shirley King - Baltimore, Md. 21224</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO - PULMONARY ARREST</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE COR PULMONALE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/10/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski - 1005 Dundalk Ave. 21224</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1983</b>		25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Helen Horner Young</b>						2a. DATE OF DEATH MONTH <b>10</b> DAY <b>16</b> YEAR <b>83</b>		2b. HOUR <b>4:15</b> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>17</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Edgewood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1017 Woodson Rd. 21212</b>	
14. FATHER'S NAME FIRST <b>Anderson</b> MIDDLE <b></b> LAST <b>Horner</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Etta</b> MIDDLE <b></b> LAST <b>Unknown</b> ✓					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213-74-4433</b>		17. INFORMANT ADDRESS <b>Isabelle Mallonee 602 W. Joppa Rd. 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>					
22a. I certify that (1) this hospital attended the deceased from <b>12/21</b> 19 <b>71</b> to <b>10/16</b> 19 <b>83</b> that (1) (we) lost saw the deceased alive on <b>10/13</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Meredith Smith MD</b> DEGREE <b>MD</b>								22c. DATE SIGNED <b>10/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Meredith Smith MD</b>				22e. ADDRESS <b>1900 E. Northern pkwy 21239</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld</b> ADDRESS <b>6500 York Rd.</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DDHMC - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ISAAC		2a. DATE OF DEATH MONTH DAY YEAR 10 29 83	
3 SEX Male		7b. HOUR 5:00P M	
4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 17 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2329 HARLEM AVENUE 21216	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRACKMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2329 HARLEM AVE. 21216			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM YOUNG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA MOORE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS MIMIE YOUNG 2329 HARLEM AVENUE 21216			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Terminal lung Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 1629		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>6/10/83</u> to <u>10/29</u> 19 <u>83</u> , that (b) <u>0</u> saw the deceased alive on <u>10/28</u> 19 <u>83</u> , and that in my opinion death occurred on the date and hour and from the causes stated above, (b) <u>0</u> (did) (did not) view the body after death.			
22b. SIGNATURE Darrell M. Gray, M.D.		22c. DATE SIGNED 10/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Darrell M. Gray, M.D.		22e. ADDRESS 2329 Arundel Ave. Balto MD. 21216	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE 11-4-83	
23c. NAME OF CEMETERY OR CREMATORY SHADY GROVE A.M.E. CH.		23d. LOCATION CITY OR TOWN COUNTY STATE WINNSBORO SOUTH CAROLINA	
24. FUNERAL DIRECTOR NAME ADDRESS E.L. PHILLIPS 1721 - 27 NORTH MONROE ST.		25a. DATE REC'D. BY REGISTRAR NOV 3 1983	
25b. REGISTRAR'S SIGNATURE John J. Connelley			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Paula</i> MIDDLE <i>Zeller</i> LAST <i>ZELLER</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10/07/83</i>		2b. HOUR <i>10:25 AM</i>	
3. SEX <b>FEMALE</b>	4. RACE <i>W</i> <b>HITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 13 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STREET ADDRESS <i>APT. 303</i> <i>2500 W. BELVEDERE AVE., 21215</i>			
13a. STATE <i>md.</i>	13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>ABRAHAM</b> MIDDLE LAST <b>FRANK</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MALCHEN</b> MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-12-3889</b>		17. INFORMANT <b>MRS. RUTH BOKKIS</b> <b>3412 MIDFIELD RD. BALTO., MD 21208</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Intracranial Bleed w/ midline shift**2384*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *? Polycythemia Vera on blood*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

1) *ASCVD w/ CHF* 2) *Polycythemia Vera* 3) *UTI*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Risa Burns</i>	DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>10/7/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Risa Burns</i>	22e. ADDRESS <i>Sinai Hospital</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>OCT. 9, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHEVRA AHAVAS CHESED</b>	23d. LOCATION <b>RANDALLSTOWN BALTO. MD</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 11 1983</b>	25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>

